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Korean American dementia caregivers' attitude toward caregiving: The role of culture

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Dedication

To my father and parents-in-laws who are in heaven for their love and care to me.

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Korean American dementia caregivers' attitude toward caregiving: The role of culture

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The purpose of this study was to explore how Korean American caregivers view dementia caregiving and analyze the role of culture in their attitude toward caregiving. Demographic characteristics, stressor factors, social support factors, and cultural factors were examined in the model. Stressor factors were measured by care receivers' problem behaviors, duration of caregiving, and amount of caregiving. Social support factors were composed of the amount of social support and the quality of social support. Cultural factors included level of acculturation, years in the U.S., filial piety, and familism. The study compared a group of spouse caregivers with a group of children providing care in order to investigate the differences in their attitude toward caregiving. In addition, the interaction effect between social support and acculturation on dementia caregiver's attitude toward caregiving was examined.

Eighty five Korean American dementia caregivers participated in the survey through a convenience sampling method. Among the Korean American dementia caregivers, child caregivers showed a more positive attitude toward caregiving then spouse caregivers. The effects of social support on caregivers' attitude toward caregiving did not vary with the level of acculturation. Hierarchical multiple regression analysis indicated that, among the study factors including stressor factors, social support factors, and cultural factors, only social support factors contributed significantly to Korean American dementia caregivers' positive attitude toward caregiving. Among the predictors of Korean American dementia caregivers' attitude toward caregivng, the amount of caregiving per day was the most significant variable, followed by the quality of social support and care receivers' problem behaviors. Higher levels of daily caregiving and higher quality of social support were positively related to positive attitude toward caregiving. A higher level of care receivers' problem behaviors was negatively related to positive attitude toward caregiving.

Comparison of the beta coefficients from the spouse caregiver group and non-spouse caregiver group revealed that there was a discrepancy of predictors of Korean American caregivers' attitude toward caregiving between the two caregiving groups. The model had a better fit for immigrant spouse caregiver groups indicated by significantly different R^2 from spouse caregivers and non-spouse caregivers, 85% and 33%, respectively. The results of this study imply the importance of incorporating cultural diversity in social policy. Because of the salient findings in this study, inclusion of content on increasing and enhancing quality of social support is recommended for social work practice with Korean American dementia caregivers.

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CHAPTER I

INTRODUCTION

Problem Statement

Scientists estimate that Alzheimer's disease currently affects up to four million people (National Institute of Aging, 2003) and, by 2050, 14 million Americans will be affected if no treatment becomes available (Hebert, Beckett, Scher, & Evans, 2001). Alzheimer's disease and other forms of dementia are two of the leading diseases that require significant utilization of formal and informal resources (Acton & Kang, 2001; Ory, Yee, Tennstedt, & Schulz, 2000). More than seven million persons in the U. S. currently provide informal care to older adults, with five million of those providing care for adults fifty years of age and older with dementia (The National Women's Health Information Center, 2004).

The value of the time contributed by dementia caregivers is estimated at 257 billion dollars annually (National Alliance for Caregiving, & AARP, 2004). The per capita annual cost of providing informal care to elderly people with dementia was estimated to be $18,385 in 1998, and all aspects of costs increase with disease severity (Moore, Zhu, & Clipp, 2001). Privately paid home care or nursing-home care can cost up to $40,000 a year (Doka, & Carter, 2001). Even though Medicare may cover part of the medical cost for the patient, caregiving families still spend an average of $5,800 yearly for nonreimbursable

services, and their financial expenditures can increase to more than $10,000 per year until the end of the long caregiving journey (Aoronin, 2004).

It has been recognized that caregiving for a demented family member is typically an expression of love and dedication, but it can also be extremely challenging and have adverse effects, such as a sense of burden and feelings of depression, anxiety, insomnia, and so on (Schulz, 2000). Caring for a demented relative and coping with the loss of intimate exchanges in their relationship require many changes in a family's life. Many researchers and clinicians associate the caring experience with long-term exposure to numerous stressful events (Connell, Janevic, & Gallant, 2001; Nolan, Grant, & Keady, 1996). A national survey of 1,247 caregivers reported that most caregivers experienced physical strain (67 percent rate on a one or two on a five point scale), emotional stress (44 percent), or financial hardship (77 percent) as a result of being a caregiver (National Alliance for Caregiving, & AARP, 2004). It is clear that a long-term disease such as dementia can endanger a caregiving family's general sense of well-being and its financial security.

Despite psychosomatic and negative outcomes that may accompany providing dementia caregiving, the caregivers also may experience reward throughout the long journey. Research findings show that female caregivers gain a sense of self-worth and mastery, qualities associated with greater family cohesion and marital satisfaction (Martire,

Stephens, & Atienza, 1997). Caregivers value positive aspects of relationships with their impaired family member. In addition, they appreciate their own feeling of confidence that giving care provides them (Farren, Miller, Kaufman, Donner, & Fogg, 1999). Despite the growing evidence concerning the positive side of dementia caregiving, much dementia caregiving research still focuses on its pathologic aspects.

Lawton, Moss, Kleban, Glicksman, and Rovine (1991) suggested that negative affect and positive affect in caregiving are different from each other and that both concepts are essential for a comprehensive understanding of psychological well-being. This concept is also delineated in Lazarus and other associates' (DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982) stress and coping model. They described "up-lifts" (e.g., what makes person feel good, joyful, or satisfied) as moderating the negative effects of stress on well-being.

Korean American Dementia Caregivers' Attitude toward Caregiving

The minority elderly population in this country is growing (National Alliance for Caregiving, & AARP, 2004), and Korean American older adults are one of the fastest growing groups. There were about 3,270 Korean elders in the U.S. in 1970 (Koh & Bell, 1987) and in 1990, the number increased to 34,248 (Moon, 1996). According to the U. S. Census of 2000, Koreans are the forth largest Asian group in the U. S. There were

1,076,872 Korean-Americans were Korean alone, which means both of their parents are Koreans, and 1,228,427 Korean Americans who were Korean alone and in combination with other ethnic population. Among the Korean alone group, there were 66,254 elders (6.18%) who were sixty five years and over. Only 6% (4,284) of them were born in the U. S., and 94% of the Korean American elders were Non-U.S. born' (U.S. Bureau of Census, 2000). A common reason for them to immigrate to the U. S. was maintenance of family ties (Watari, & Gatz, 2004). Indeed, Korean American families with older adults tend to keep their original cultures within their family system even though they may have been away from their original country for several decades.

As the number of Korean American older adults increase, the population of dementia patients and caregivers also grows. Family caregivers are significant social resources across cultures. Despite a need for resources for and information concerning this growing population, there is limited information on Korean American dementia caregivers. Korean American caregivers can be expected to be different from western dementia caregivers due to difference in norms, practices, and expectations concerning their role (Lee & Farren, 2004).

In Korea, it is estimated that there are 280,000 dementia patients, which is 8.3% of the 3,370,000 Korean elderly population aged 65 or over in 2000 (Korean Ministry of Health and Welfare, n.d.). With the aging population growing fast, it is expected that the dementia

population will grow to 50 million by 2020 (Korean Ministry of Health and Welfare, n.d.). The majority of Korean dementia caregivers are daughters-in-law (42.7%) or sons and daughters (24.3%). Korean dementia caregivers have been found to experience insomnia, depression, anxiety, and financial stresses due to the long-time caregiving process. However, 71% of the caregivers still say that they are going to keep their parents at their home. Only 12% of them reported they wanted to use nursing home service (Kwon, 2002).

Korean American dementia caregivers, given their biculturalism, may struggle with acculturation stresses, particularly the cultural discrepancies between the maintenance of their original family-focused culture in the face of Western individual-focused culture. Youn, Knight, Jeong, and Benson (1999) discovered that Korean and Korean American dementia caregivers had higher familism than White caregivers. Korean and Korean American caregivers, however, presented higher burden, anxiety, and depression than their counterparts. Relatively little is known regarding the effect of caregiving on caregivers among the Korean American population in the United States. The role of acculturation and social support on the caregiver's positive attitude toward caregiving has not yet been studied thoroughly despite clearly growing needs.

Aranda and Knight (1997) suggested that ethnicity as a culture is a structural status variable that also impacts each element in their sociocultural stress and coping model. The authors suggested that minority ethnicity culture explains their appraisal and coping skills

in the dementia caregiving context. Such a context can be formed with unexpected directions. Korean American dementia caregivers, for example, would receive support from their family network and benefit from familism. However, their culture of familism also can hinder utilizing professional help, and burden the culturally-expected main caregiver who is generally a daughter or a daughter-in-law. Without including an understanding of specific cultural features such as familism or filial piety, minority dementia caregivers' positive attitude toward caregiving cannot be adequately explained.

Purpose and Significance of the Study

This dissertation aims to extend the important research of the Two factor model of Lawton, Moss, Kleban, Glicksman, and Rovine (1991) and the Sociocultural stress and coping model of Aranda and Knight (1997) in a multiethnic cohort of dementia caregivers. These models will be applied to Korean American dementia caregivers to test factors contributing to their attitude toward caregiving, with the assumption of the coexistence of both positive and negative aspects of caregiving. The primary purpose of this research is twofold: (1) to investigate the role of stress factors, social support, and other cultural factors in Korean American dementia caregivers' attitude toward caregiving; and (2) to identify the best predictors of a Korean dementia caregiver's attitude toward caregiving among stressor factors, social support, and cultural factors.

The results from this study will contribute to social work research and other health related research areas in multiple ways. First, it will provide culturally sensitive information and insight to help professionals and researchers. Even though Asian Americans seem to share several cultural elements, such as familism (Hicks & Lam, 1999), the heterogeneity of the Asian American population must be appreciated by clinicians and researchers. Asian American dementia caregivers, including Korean American caregivers, can potentially benefit from social work treatment consistent with their values and cultural nuances.

Second, it will help social work practitioners to approach dementia caregivers with a strengths-based approach. Thinking about benefits may help Korean American caregivers process adverse events in important ways. Research shows that an adverse event, once perceived as meaningful or understandable, seems less harsh to the person who experienced it (McMillien, 1999). Finding ways caregivers have benefited from adversity can help them continue to believe that they deserve good things and that only good things will happen to them. Helping professions can encourage the caregivers to share their perceptions of benefit and growth during the process. When caregivers acknowledge their growth to other caregivers and professionals, it has the potential to strengthen caregivers' inner-self power.

Lastly, it will suggest public policy that encourages minority family caregivers' longer involvement in dementia caregiving. Culturally sensitive and strengths-based public

policy for dementia caregiver will provide ideas for practitioners to serve Korean American caregivers' well-being. It will ultimately delay dementia patient's institutionalization and save national health care costs.

CHAPTER II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This chapter includes a literature review of the factors influencing Korean American dementia caregivers' attitude toward caregivng. It also presents the conceptual framework that guides the study.

Literature Review

A Biopsychosocial and Spiritual Overview of Dementia Caregiving

This section of the dissertation presents a discussion of the biological, psychological, social, spiritual, and family background factors related to dementia caregiving.

Biological Factors

Dementia defined. According to *DSM-IV-TR* (American Psychiatric Association, 2000), dementia refers to

> The development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia (deterioration of language function), apraxia (impaired ability to execute motor activities despite intact motor abilities, sensory function, and comprehension of the required task), agnosia (failure to recognize or identify objects despite intact sensory function), or a disturbance in executive functioning (the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior) (p. 148).

Types and stages of dementia. There are many types of dementia including "dementia of the Alzheimer's type, vascular dementia, dementia due to HIV disease, dementia due to head trauma, dementia due to Parkinson's disease, dementia due to Huntington's disease, dementia due to Pick's disease," and so on (American Psychiatric Association, 2000, pp. 163-166). Among the different types of dementias, Alzheimer's disease is the most common, accounting for 50% to 70% of all dementias (Agronin, 2004). Age is a critical risk factor in dementia prevalence, where the prevalence rate in 65 years is 3% and it increases up to 47% after 85years (Hebert, Scherr, Beckett, Albert, & Pilgrim, 1995). Dementia progresses slowly, where the average length of the disease from observed onset to death is seven years and it ranges from two years to eighteen years (Turner, 2003).

Health and physical impact on caregivers. The major population of dementia caregivers is older adults who have biologically-based concerns of their own. When they experience the burden of caregiving for a long period of time, their health can be threatened. Kolanowski, Fick, Waller, and Shea (2004) showed that spouses with dementia patient were more treated for anxiety disorders, rheumatologic disease, and diabetes. The dementia caregivers also had more emergency room visits. Caregivers providing care for family members over the age of fifty routinely underestimate the length of time they will spend as caregivers. Only forty-six percent expected to be caregivers longer than two years. In reality, because of the physical, medical, or frailty issues of the older adult, the average

length of time spent on caregiving was about eight years, with approximately one third of respondents providing care for 10 years or more (MetLife Mature Market Institute, 1999).

Research suggests that dementia care status does not appear to have a consistent physical health impact on dementia caregivers. For example, Schulz and Beach (1999) conducted a prospective population-based cohort study from 1993 to 1998 with a total of 392 caregivers and 472 noncaregivers. They tested four-year mortality rates and found out that caregivers who experienced caregiving strain had a 63% higher mortality rate than noncaregivers, after controlling for sociodemographic factors, prevalent disease, and subclinical cardio-vascular disease (Schulz & Beach, 1999). Pinquart and Sorensen's (2007) meta-analysis proved that higher age, lower SES status, and lower informal support were related to caregiver's lower physical health. In detail, the study articulated that the caregiving stressor had a stronger association of physical health among older people, dementia caregivers, and men.

On the other hand, the Canadian study of health and aging working group (2002) studied a nationally representative sample of 948 dementia caregivers. The research was conducted longitudinally with a 4 to 5.9 years of interval between the two measurement points. They found that caregiving burden does not directly translate into deteriorating health. Therefore, specific information from caregivers on their health concerns should be obtained for adequate research and practice. This dissertation, therefore, will explore how

stress factors, including a care recipient's problem behavior, amount of daily caregiving, and lengths of caregiving, affect caregivers' psychological well-being.

Psychological Factors

Many caregivers experience psychological changes during caregiving, such as experiencing high levels of burden (Gaugler, Kane, Kane, & Newcomer, 2005; Pinquart & Sorensen, 2003), emotional and physical strain (Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999), depressive symptoms (Covinsky et al., 2003), social isolation (Schulz, O'brien, Bookwala, & Fleissner, 1995), and anxiety symtomatology (Rose-Rego, Strauss, & Smith, 1998).

Problem Behaviors, Burden, and Depression. A dementia patient's severe and early problem behaviors may have harmful and long term effects on his or her caregiver (Gaugler, Kane, Kane, & Newcomer, 2005). In Gaugler, Kane, Kane, and Newcomer's (2005) study, caregivers who experience the recipient's deleterious behaviors in the early stages of dementia showed increased burden and depression over the three year research period. Pinquart and Sorensen's (2003) meta-analysis with 228 studies showed dementia caregivers are most burdened when care recipients exhibit problem behaviors despite the amount of care provided. Caregivers' self-rated health, perceived stress, and life satisfaction were also linked with their psychological health (Schulz, O'Brien, Bookwala, & Fleissner, 1995).

Strain. Ory and colleagues (1999) analyzed data from 1,509 family caregivers in the 1996 National Caregiver Survey. They argued that the dementia caregiving experience is unlike any other type of caregiving, contributing to a higher level of emotional and physical strain than other types of caregiving situations. Controlling for intensity of caregiving involvement and socio-demographic characters such as gender, age, race, education, and income, dementia caregiving status was still a significant predictor of emotional and physical strain (Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999).

In another study, McKibbin, Walsh, Rinki, Koin, and Gallagher-Thomson (1999) found caregivers consume more alcohol than non-caregivers. In addition, Schulz, et al. (1995) reported dementia caregivers take more psychotropic drugs than noncaregivers. These research outcomes highlight dementia caregiving as a unique and complicated experience to study.

Depression. Depression is a common symptom associated with the dementia caregiving experience (Covinsky et al., 2003; Miller, et al., 2001; Pinquart, & Sorensen, 2003; Schulz, et al., 1995). In Schulz, et al.'s (1995) review of forty one dementia caregiving studies, all research from 1990 to 1995 reported increased depressive symptoms compared to nondementia caregivers. Across forty one studies, psychiatric mobility (mostly depression and anxiety) was related to patient problem behaviors and income.

Covinsky and colleagues' cross-sectional (2003) study of 5,627 dementia family

caregivers reported that almost one-third (32%) of the caregivers presented six or more symptoms of depression on the 15-item Geriatric Depression Scale (GDS). Conducted with a geographically and ethnically diverse population, this study was one of the largest investigating dementia caregivers' depression. The independent factors that predicted caregiver depression were low income, the relationship to the patient (being a daughter or wife compared to being the son of a male patient), hours spent on caregiving, and poor caregiver functional status (Covinsky, et al., 2003).

Depression or Anticipatory Grief. Since dementia is a long-time disease, it is sometimes referred to as an ongoing funeral (Doka & Davison, 1998). Through the ongoing funeral process, caregivers experience anticipatory grief that has the potential to be beneficial when, as practitioners put it, it supports "early" expressions of loss around the familiar behaviors of a loved one. The question becomes whether the depression is solely depression or an expression of anticipatory grief.

Walker and Pomeroy (1996) attempted to distinguish dementia caregivers' anticipatory grief from depression. A hundred dementia caregivers' anticipatory grief and depression were measured by the Grief Experience Inventory (GEI) and the Beck Depression Inventory (BDI). The intensity of grief explained almost half of the variance in depression when controlling for length of caregiving time, support group attendance, gender, relationship with care receiver, and knowledge of dementia (ibid.). This study

reveals the importance of accurately assessing a client's feelings and sense of despair in the long-term caregiving process and the need for timely intervention.

Positive aspects of caregiving. Many caregivers report they experience reward from the caregiving experience. Cohen, Colantonio, and Vernich's (2002) research reveals that positive feeling about caregiving is negatively related to depression, burden, and poor health. Two hundred and eighty nine (289) dementia caregivers were asked about their perceptions of positive aspects of cargiving. Two hundred and eleven (211) caregivers (73%) answered that they could find a positive aspect of caregiving. Specific responses concerning positive aspects of giving care included experiencing companionship (22.5%), feeling a sense of fulfillment and reward (21.8%), experiencing enjoyment (12.8%), and achieving a sense of duty and obligation (10.4%).

Tarlow, Wisniewski, and Belle (2004) developed a new measure for positive aspects of caregiving with dementia caregiving. Their measure was used to test 1,229 dementia caregivers. It proved to be statistically reliable and valid. Dementia caregivers who participated in the study mentioned that caregiving made them feel "needed, useful, and good about themselves" (p. 446). They also reported that "it enabled them to appreciate life more, to develop a more positive attitude toward life, and strengthened their relationships with others" (p. 449). Such research outcomes emphasize the necessity of practitioner-conducted comprehensive assessments of how the caregiver perceives both the

negative and positive aspect of dementia caregiving.

The dissertation will examine the extent of dementia caregivers' positive attitude toward caregiving in light of other contributing factors such as stress factor, social support, and cultural factor. A more thorough literature review on positive aspects of dementia caregiving will be provided in a later section.

Appraisal. There is extensive literature demonstrating that the caregiver's appraisal of the caregiving experience plays a central role in the relationship (Harwood, Ownby, Burnett, Barker, & Duara, 2000; Hooker et al., 2002; Pot, Deeg, Dyck, & Jonker, 1998; Rapp & Chao, 2003). Harwood et al. (2000) showed that appraised burden mediated the relationship between objective stressors, caregiving resources, caregiver ethnicity, and adaptational outcome of depression. In this study of 114 dementia caregivers, the authors demonstrated that subjective appraisals of stress, rather than the role of objective stressors, are important in determining a dementia caregiver's well-being. First of all, the result confirmed the direct relationship between care receiver's functional limitation and caregiver's depression. The result supporting the negative appraisal of caregiving experienced, however, was significantly correlated with a care receiver's higher functional limitation and disturbances, caregiver's poor health, and lower social support. The result did not support the relationship between caregiver ethnicity and appraisal of caregiving experience. A limitation of this study is the inclusion of only depression, rather than negative and positive aspect of caregiving, in

evaluating dementia caregiver's psychological well-being.

Hooker et al.'s (2002) study with sixty-four dementia patient-caregiver dyads showed that care receivers' increased problem behaviors and prolonged caregiving were strongly associated with a caregiver's worsening mental and physical health. However, the relationship between the dementia patient's behavioral and psychological symptom and the caregiver's mental and physical health is mediated through stress appraisal.

In a similar vein, research by Rapp and Chao (2000) tested the effect of appraisals of strain and gain on the psychological well-being of dementia caregivers. Their results showed that once caregivers' appraisal of strain and gain are factored in the regression analysis, care receivers' problem behaviors do not predict negative affect of caregiving. Appraisal of strain predicted 20% of the negative aspects of caregiving, while appraisal of gain predicted 4% of it. None of them predicted positive aspects of caregiving. The study confirmed that positive appraisals of caregiving buffer caregiving stress and that they are independent from negative appraisals. The authors support the view that interventions to modify dementia caregivers' appraisals of the experience can enhance their psychological well-being by lessening psychiatric stress (Rapp & Chao, 2000).

Pot, Deeg, Dyck, & Jonker (1998), studying 158 dementia caregivers in the Netherlands, also showed the mediator effect of caregiving appraisal on dementia caregivers' psychological distress. Interestingly, this study described the different role of

appraisal of caregiving in caregiver's psychological distress. For non-spousal caregivers, the effect of stressors, such as problems behaviors, on their psychological distress was mediated by the appraisal of perceived pressure. However, the mediator effect was not found with spousal caregivers. This finding supports the idea that spousal caregivers are not disturbed by ideas of being burdened or negative appraisal of caregiving.

Social Support Factors

Social support has been found to be an important determinant of a dementia caregiver's well-being. In Chapell and Reid's (2002) research, 243 Canadian caregivers showed that perceived social support was positively related to their general well-being. In a study of depression, quality of life, and perceived benefit among caregivers, Rapp, Shumaker, Schmidt, Naughton, and Anderson (1998) found that social resources constituted the most significant factor related to a caregiver's well-being. Controlling for socio-demographic characteristics of caregivers' and care receivers' problem behaviors, caregivers reported that they felt less depressed, experienced better quality of life, and perceived more benefit from caregiving when they were able to use skills to obtain more resources**.**

Despite the benefits of social support, many caregivers are left alone until their physical and mental health is in danger. Loneliness and social isolation are often associated with dementia caregivers' increasing depression. Secondary analysis among 242 caregivers by Beeson, Horton-Deutsch, Farran, and Neundorfer (2000) showed that caregivers'

depression is significantly predicted by loneliness, relational deprivation, quality of the current relationship, and distance felt due to caregiving. However, loneliness was the only significant predictor of caregiver depression when husbands, wives, and daughters were tested separately as groups.

Tebb and Jivanjee (2000) underscore the importance of early intervention on dementia caregivers' isolation and lack of social support. Their qualitative study on dementia caregivers' isolation articulated multidimensional causes of isolation including environmental isolators (lack of providers' information on dementia and caregiver needs, societal views on aging, and lack of community support) and individual isolators (role changes, loss of companionship and social relationships, limited knowledge of resources, and inadequate income to access social activities).

Quality of social support vs. amount of social support

In the assessment of caregivers' social functional capacity, it is important to investigate perceived social support and social ties/integration separately. Thoit (1995) held that social integration is positively related to physical/mental health but cannot buffer physical or emotional effect of continuing difficulties in one's life. Perceived emotional social support, however, is directly related to good physical and mental health and also buffers the damages a person receives from major life crisis. A further distinction can be made concerning caregiver support systems. In Stuckey and Smyth's (1997) study of 203

dementia caregivers, social support (functional support) was distinguished conceptually from social support. A caregiver's subjective awareness of social ties was a stronger predictor of positive health outcome than their objective amount of social ties. This research outcome suggests the importance of investigating both subjective perceptions of and actual quality of social support in caregiving.

The dissertation will investigate the role of social support, composed of amount of social support and satisfaction with the support, on dementia caregivers' attitudes toward caregiving.

Spiritual Factors

Many studies have shown the role of spirituality--a universal human phenomenon (Chiu, Emblen, Hofwegen, Sawatzky, & Meyerhoff, 2004)--in reducing dementia caregivers' burden (Picot et al., 1997; Farren, Paun, & Elliott, 2003, Roff et al., 2004). It is therefore another pertinent area to assess in caregiving situations. For example, Crowther, Parker, Achenbaum, Larimore, and Koening (2002) argued that positive spirituality enhances elders' physical and psychological well-being. They also suggested that Rowe and Kahn's successful aging model, which is based on the older adult's ability to engage in an active life, minimize risk and disability, and maximize physical and mental abilities, should be extended to incorporate positive spirituality.

Farran, Paun, and Elliot (2003) provided a spiritual model for dementia caregivers based on their qualitative research with multicultural caregivers including African American, Latino, Caucasian, and other ethnicities. The forty three respondents articulated the importance of faith in their lives and how they benefited from spirituality during the dementia caregiving experience. They concluded that the combination of preexistent faith and more recent gains from spirituality can contribute to the meaning of the caregiving experience (Farran, Paun, and Elliot, 2003).

In Koening's (2005) qualitative study, dementia caregivers disclosed that spirituality gave them a "sense and meaning and purpose as a caregiver" (p.164). They would feel guilty if they relied on outside help since caring for their loved one is their "soul" responsibility. Spirituality helped them to resolve their ethical caregiving dilemmas. Caregivers also used spirituality as a way of transcending complicated decision-making. One interviewee stated, "I am just so happy and grateful that she [the care receiver] is still here with me. I just wouldn't consider nothing hard" (p.167). In a similar study by Paun (2003), spirituality was an important factor that empowered African American caregivers to find ultimate meaning to overcome harsh caregiving situations (Paun, 2003).

Family System Factors

Due to the interdependence of each family member in the system, family functioning, along with the caregiver's and the care recipient's biopsychosocial-spiritual

factors, is an important factor in dementia caregiving. There are several studies that point to the family characteristics enhancing caregiving situations. For example, Heru, Ryan, and Iqbal (2004) reported that dementia caregivers with poor family functioning reported higher levels of strain and burden. This in turn disrupted communication. In their study, poor problem-solving skills were also related to high strain, while good problem-solving skills were an important component in family resilience (Greene & Livingston, 2002).

Role transitions. In the functional age model, the family is considered a system, and family roles reflect the family's developmental patterns. Role changes and transitions are inevitable as changes in the family developmental process take place (Greene, [1986] 2000). In multigenerational families, caring for an aging or ill parent is a developmental task. Sherrell, Buckwalter, and Morhardt (2001) studied the midlife developmental tasks of adult child in caring their older parents. They argued that when their parents need children's protection, adult children should "shift their own identity toward consolidation of an adult sense of self and individualism" (p. 387). This perspective on caring for parents during midlife is different from views that suggest midlife is a time of personal freedom and autonomy. The successful task accomplishment can enhance caregivers' self-esteem and promote their resilience in the long caregiving journey.

Spousal caregivers vs. children caregivers. There are research studies arguing that spousal caregivers and children caregivers experience similar burden and physical stress (Chumbler, Grimm, Cody, & Beck, 2003; Strawbridge, Wallhagen, Shema, & Kaplan, 1997). However, many caregivers and practitioners still present that there are qualitative differences between spousal caregivers and adults children caregivers in terms of appraisal and experience of dementia caregiving (Cahill, 1997; Coen, Swanwick, O'boyle, & Coakley, 1996). Coen et al. (1996) found that daughter caregivers are likely to experience more burden compared to spousal and other kin caregivers. Cahill (1999) argued that some spousal caregivers and adult children caregivers are motivated by different reasons to care for a relative with dementia. She found that spousal caregivers are motivated by powerful obligation which is created by "a long and fulfilling marriage, including a history of a shared past and a commitment to a shared future" (p. 241). A spousal caregiver said "I just cared for him. I didn't even question it. He was my husband. We'd been married 50 years. I preferred to do it myself because I knew his little ways and idiosyncrasies" (p.241). Answers from children caregivers were somewhat different, which encompass inescapable moral obligations and contextual constraints. One daughter caregiver said "Duty had a lot to do with it. She had nobody else. She made me her next of kin without consulting me" (p.241).

Sandwich-Generations. An example of potential role conflict can be found among sandwich generation female caregivers who care for frail parent and their children at home.

They are also predisposed to health and psychological problems (Tebes, & Irish, 2000). Along with potential health issues for the caregiver, younger children of the caregiver are also vulnerable given their mother's stressful situation. Tebes and Irish (2000) tested family-focused mutual help intervention for such families, which was found to reduce depressive symptoms and decrease the negative impact of caregiving. In addition, the children who participated in the intervention group showed increased global functioning along with an increase in social competence.

Demographic factors relating caregiver's well-being

In this section, the relevant literature on demographic factors of the caregiver and care receiver, which include age, gender, income, education, relationship with care receiver, and co-residency, related to dementia caregiver's psychological well-being is presented.

The literature about the relationship between caregiver's *age* and psychological well-being is inconsistent. In Russo et al.'s (1995) study, younger caregivers showed significantly higher depression. Harwood et al. (2000) showed that the caregiver's age is a significant predictor of appraisal of satisfaction in the caregiving situation, in which older caregiver presented higher satisfaction. Tornatore and Grant (2002), however, found that older caregivers felt more burdens from dementia caregiving. In their research, age was the only statistically significant demographic factor associated with caregiver's burden.

The literature suggests that *female* caregivers seem to experience more psychological morbidity than *male* caregivers. Miller and Cafasso (1992) showed that female caregiver reported more burden than male caregivers. Female caregivers are more involved in personal care and household tasks. In Ashley and Kleinpeter's (2002) study, female caregivers were more depressed than men. The researchers also found that female caregivers used more avoidance coping strategies than male caregivers. Yee and Schulz (2000) confirmed the gender differences in caregivers' mental health. Female caregivers reported more depression, anxiety, general psychiatric symptoms, and lower life satisfaction. The researchers argued that the vulnerability of female caregiver can be partially explained by female caregiver's escape-avoidance coping mechanism and higher engagement in day-to-day caregiving tasks, which require intensive energy.

The literature indicates that lower *income* and financial inadequacy is related to caregiver's mental health. Convinsky et al. (2003) found that caregiver who had lower household income reported more depression. Schulz et al. (1995) also proved the negative relationship between income and psychiatric morbidity. Income is also positively correlated with caregiver's life satisfaction. Lee, Brennan, and Daly (2001) found caregivers with higher income appraised the caregiving situation as more satisfactory and beneficial. Caregivers with higher income also reported less depression. In Russo et al.'s (1995) study, however, income was not related to a caregiver's mental health. The relationship between education

and caregiver's psychological well-being is inconclusive. Ory et al. (1999) found that higher education of dementia caregivers is a predictor of higher emotional strain in the caregiving process. In Covinsky et al.'s (2003) research, less educated caregivers showed higher depression. Some studies (Dura, Stukenberg, & Kiecolt-Glaser, 1991; Hooker et al., 2002; Rapp, & Chao, 2000) report that education of caregivers is not significantly related to his/her mental health.

Many research studies show that *adult children* caregivers experience more negative aspects of caregiving than *spousal caregivers* (Cahill, 1997; Coen, Swanwick, O'boyle, & Coakley, 1996). In Lawton et al.'s (1991) study, for example, the psychological well-being of adult children caregivers, unlike spousal caregivers, was very sensitive to the amount of care they provided and the extent to which there was an appraisal of the burden. The authors argued that the different results for the two groups could be explained by their different perceptions of caregiving. For spousal caregivers, a caring husband/wife is part of an experience of marital commitment and human development. Therefore, the objective caregiving workload does not impact the spousal caregiver's appraisal of burden and psychological well-being. For children caregivers, however, caring for a parent is an extra activity in addition to current roles. Therefore, they are more burdened, and their psychological well-being is challenged by the amount of caregiving workload (Lawton et al., 1991).

Some researchers, however, argue that spousal caregivers are more vulnerable to psychological and physical morbidity in some aspects. In Pinquart and Sorensen' (2003) review, spousal caregivers showed higher levels of burden and depression, and lower subjective well-being than other caregiving groups. Hooker et al. (1998) mentioned that spousal caregivers are already fragile populations due to their own health issues and lack of social support. Therefore, this population is an ideal caregiving samples to examine chronic stress, the immune system, and cardiovascular response (Hooker et al., 1998).

Interestingly, co-residency brings divided results in caregiving research. One would expect that co-residency will bring higher burden and depression. Zanetti et al., (1997) showed that caregivers who co-reside with their care receivers had higher depression and burden than the caregivers who live apart from the care receivers. In fact, some studies prove that co-residency is not significantly related to caregiver's mental health (Russo et al., 1995; Song, Biegel, & Milligan, 1997). These inconsistent results infer that institutionalization of the care receiver is not the end of caregiving but continuum of caregiving (Clyburn, Stones, Hadjistavropoulos, & Tuokko, 2000). The Canadian study of health and aging working group (2002) documented that the depression of dementia caregiver group did not disappear even after the care receivers' institutionalization.

The role of care receiver age's and gender on caregiver's mental health have been investigated along with caregiver's demographic factors. Care receiver's age and gender do

not have a distinguishing relationship with caregiver's mental health. In Covinsky et al. (2003) study, care receiver's age was a significant predictors along with dementia severity where younger dementia caregiver showed higher depression. Care receiver's gender, however, did not have a significant relationship with caregiver's depression in the same study. Noonnan and Tennstedt (1997) also found that the care receiver's age and gender were not significant predictors of caregiver's depression and self-esteem.

The Role of Culture in Dementia Caregiving

In 2003, minorities represented 17.6% of the U. S. elderly population, and the proportion is expected to increase to 26.4% in 2030 (Administration on Aging, 2004). With the growing population of minority caregivers in the U. S. (National Alliance for Caregiving, & AARP, 2004), it is necessary to better understand a cultural conceptualization of caregiving. Culture plays an important role throughout the whole period of dementia caregiving, including designating a main caregiver, decision-making during the experience, utilizing outside help, institutionalizing a loved one, and healing through the bereavement process. Moreover, it is necessary to use cultural information to teach minority dementia caregivers problem-solving skills and active coping skills to improve their well-being.

For example, the cultural socialization and sense of duty to family members of African American caregivers play important roles in the perception of dementia caregiving

along with their general health. Dilworth-Anderson, Goodwin, and William (2004) found that cultural justifications such as cultural expectations in providing care contribute to African American caregivers' long-term physical health. A comparison study of dementia caregivers from multiple cultures reveals the role of culture in appraisal and coping and its impact on caregivers' psychological well-being (Adam, Aranda, Kemp, & Takagi, 2002). Such studies appear to indicate that African American caregivers exhibit lower levels of depression. The authors attributed this to African Americans' strong sense of spirituality and its relationship to the caregiving process.

Minority caregivers experience increased religiosity more in the caregiving process and benefited from it more than majorities (Navaie-Waliser et al., 2001, Haly et al., 2004). In a study by Picot and colleagues (1997), African American caregivers showed more perceived reward than their white counterparts. The burden of African American caregivers was thought to be mediated by their religiosity. Haley et al. (2004) also showed that African American caregivers use greater religious coping and have better psychological well-being than white caregivers. Without culturally sensitive knowledge, practitioners are not able to effectively assess minority caregivers. Cultural similarities are as important to address as cultural differences. Aranda (2001) argued the similarities across cultures should be attended to in order to develop interventions for caregivers from diverse populations.

Similarly, Knight, Silverstein, McCallum, and Fox's (2000) sociocultural stress and coping model emphasized the significant effect of culture on caregiving. The model refers to ethnicity as a culture as well as a structural status variable. In their research, African Americans once again appraised the caregiving situation as less stressful than their white counterparts. The authors emphasized that minority ethnic status as well as differences in gender influence the demand, appraisal, coping, and health outcome of dementia caregiving. It appears that African American caregivers are less depressed and/or burdened in the caregiving role than white caregivers (Dilworth-Anderson, Williams, & Gibson, 2002; Haley et al., 2004; Janevic & Connell, 2001). They perceive more reward from caregiving than white caregivers (Haley et al., 2004; Picot et al., 1997), and they are more positive than white counterparts in the caregiving situation (Roff et al., 2004). In addition, African American dementia caregivers show less use of psychotropic medication than white caregivers (Haley et al., 2004).

According to Roth, Haley, Owen, Clay, and Goode (2001), African American caregivers show better adaptation and less deterioration than white caregivers over the caregiving period. Both of the caregiver groups, however, present decreased physical health caused by chronic caregiving stresses. Even though minority caregivers are resilient over the course of the caregiving journey, they are still vulnerable and face many challenges (Roth, Haley, Owen, Clay, and Goode, 2001).

Economic Hardship

Still another consideration is the economic level of the caregiving family. Regardless of the caregiving status, many minorities struggle with financial hardship. Almost half of unmarried elderly Hispanic females (49%) and forty-one percent of unmarried elderly African American women are poor. Even though African American caregivers have heavier caregiving workloads than white caregivers (Naviae-Waliser et al., 2001), they are only half as likely to have paid home care service as are white caregivers (Women's Institute for Secure Retirement, 2002). Understanding the long-term effects of dementia caregiving on their physical health as well as their psychological well-being is a prerequisite for culturally competent assessment.

Dementia in Korean American Culture

Korean Americans in the U. S.

In 1903, the first 101 Korean immigrants arrived in Honolulu, Hawaii to find jobs at plantations. By 1905, more than 7,776 Koreans workers moved to Hawaii (Kim, 2004). After the first Korean immigrants arrived at the U .S., the number of Korean immigration to the states has been growing steadily (Korean American Census Information Center, 2003). According to Hurh (1998), Korean immigration history can be divided into three phases: (1) early Korean immigrants who came to Hawaii seeking jobs at plantations; (2) the post-

Korean War immigration (1951-1964), which includes Korean female married the U. S. solders, adopted Korean War orphans, and some students and professionals; and (3) the large number of Korean family immigrations subsequent to passage of the Immigration Act of 1965 (Hurh, 1998).

In the 2000 U. S. Census, there were 1,076,872 Korean Americans. Many Koreans reside in West coast or East coast. Thirty-two percent (345,882) of them live in California, and eleven percent (119,846) live in New York (U. S. Bureau of Census, 2000). According to Korean American Census Information Center (2003), almost twenty percent (19.91%) of Korean Americans were self-employed, with a median household income of $42,010. Among the Korean Americans who are twenty five years and over, 49.2% have at least a Bachelor's degree. This result, however, is debatable due to reluctance of older Korean Americans to participate in the census survey due mainly to language and cultural barriers.

Despite of long residence in the U. S., Korean Americans have retained their original culture in both family and community. Kang's (2002) interviews with second-generation Korean American college students clearly show how Korean Americans hold on to their culture. One female student said "I don't know much about the tradition, but I really do think of myself as Korean….Because I feel like my parents have really tried to instill in us just how preserve the culture. We try and carry on a lot of the traditions, like New Year's we always have a memorial service for my grandparents" (Kang, 2002, p. 81). The dissertation will

explore the role of cultural factors, such as acculturation level, familism, and filial piety, in Korean American dementia caregivers' positive attitudes toward caregiving, with the assumption of multidirectional cultural roles in a caregiver's mental health.

Normal versus Biomedical Perspectives

Korean American dementia caregivers are expected to be different from Western dementia caregivers due to different cultures, family structures, and norms in their original country (Lee & Farren, 2004). From a biomedical perspective, within western culture, dementia is viewed as an abnormal and pathological condition that is distinct from the process of so-called normal aging (Yong, & MaCallion, 2003). Dementia-related diseases are, however, regarded as part of normal aging in Korean culture (Chee & Levkoff, 2001; Lee & Sung, 1998; Watari & Gatz, 2004), and many Asian families share similar perceptions of dementia (Hinton, Guo, & Hillygus, 2000).

Chee and Levkoff (2001) reported in their qualitative study that only one in ten Korean dementia caregivers used the biomedical term "dementia" to describe her mother-in-law's disease. Koreans have called the disease *No-mang*, describing it as a part and consequence of aging, which is more accepted in the society. A Korean respondent, as reported in Chee and Levoff's (2001) study, states, "To tell the truth, I just thought that as mom just got older, her wits were diminishing. If the family members all took care of her in their house then we would have paid more attention to her but since she was at my eldest

brother's place, everyone just relaxed and didn't pay attention to her" (p. 115).

Korean families find no reason to announce their parent's memory loss, which is thought to be part of normal aging. They never speak in public about their aging parent's memory loss or participate in family support groups. This is common phenomenon in other Asian cultures also. Hinton, et al. (2000) found that one of the barriers to the recruitment of Chinese American caregivers for research is that dementia is construed as a normal part of the aging process rather than as a disease.

Familism

China and many other East Asian countries including Korea have been influenced by Confucianistic ideology (Park & Cho, 1995; Sung, 2001; Yao, 2000). Confucianism refers to "the tradition and doctrine of *literati*/ scholars. In fact, it is more than the values of group of people. It contains a socio-political program, an ethical system, and a religious tradition" (Yao, 2000, p.31). From a Confucianistic perspective, human beings are regarded as "part of natural order and the natural state. The natural state, even for human beings, ought to be one of harmony, not discord" (Ihara, 2004, p. 23). Korean culture has been strongly influenced by Confucianism, in which family cohesion and continuity are the most important components for sustaining community and the state (Park & Cho, 1995).

One of reasons that the Korean American dementia caregiving family keeps their

demented parent or spouse home despite burdensome caregiving tasks is their philosophy concerning familism. Many Korean family caregivers try to handle the issue within their family network for multiple reasons until the patient and family require professional assistance (Moon, Lubben, & Villa, 1998; Watari & Gatz, 2004). For Korean American immigrants, family has protected them from racial discrimination in mainstream U. S. culture and has provided them with the strength to survive. Familism has allowed them to celebrate their lives and to think positively about themselves in a foreign country. To discuss mental health problems with outsiders may be tantamount to tarnishing the image of older individuals and their families in the community.

The phenomenon of familism as a protective factor, which buffers the effects of risk and enhances adaptation to culture, is common in many other minority cultures in the U. S. (Bullock, Crawford, & Tennstedt, 2003; Hinton, et al., 2000). The familism of minority families, 'the perceived strength of family bonds and sense of loyalty to family' (Luna et al., 1996, p. 267), often means that families do not wish to disclose sensitive issues and seek help. This likely results in part from the widely held cultural value of familism in which families are the first, and possibly the only, place to seek help (Hicks & Lam, 1999). Many studies support minority caregivers' preference for extended family networks rather than formal services in the caregiving process (Bullock, et al., 2003; Dilworth-Anderson, Williams, & Gibson, 2002). Along with cultural barriers to health care systems, cultural expectation and

social reward play a role in minority caregivers not replacing the informal care with outside service (Bullock, et al., 2003).

Familism is an important cultural factor in dementia caregiving. However, the role of familism in caregivers' psychological and physical well-being is still confusing. In Youn, Knight, Jeong, and Benson's (1999) study, the Korean immigrants' stresses in caregiving are measured in comparison to Korean, Korean American, and White caregivers. As expected, familism is highest in Korean and lowest in the White caregivers, with Korean American caregivers in the middle. Korean and Korean American caregivers, however, report higher levels of burden, anxiety, and depression than do White caregivers. This result did not support Koreans' expectations concerning familism as a protective factor in dementia caregiving to decrease primary caregiver's emotional distress. It implies that obligatory familism actually poses a burden to caregivers rather than increases their positive appraisal of caregiving (Youn, et al., 1999). Reciprocal affective ties and instrumental social support rather than obligatory familism and filial piety would help Korean and Korean American caregivers' psychological well-being (Yong, & MaCallion, 2003).

Knight et al.'s (2002) research discovers some interesting relationships among familism, burden, and distress of six dementia ethnicity groups, White, African American, Latino, Japanese American, Korean American, and Korean. First, it shows that White caregivers have lower familism than four other dementia caregiver groups, and immigrant

caregivers presented lower familism as they were less acculturated to U. S. norms. However, the research showed that relationships among familism, burden, and distress were inconsistent across the ethnicities. Among Latinos, for instance, cultural orientation has a positive effect, with respect to lower levels of burden, but no impact on depression. Moreover, Japanese American caregivers showed that higher familism was correlated with higher burden and depression, which contradicts the general assumption concerning the role of familism in the society. Korean American samples also demonstrated that familism does not contribute to lowering depression and burden.

Overall, familism was not related to dementia caregivers' depression and burden. In some groups, it actually had a negative effect on caregivers' psychological well-being. The researchers suggest that explanations of the confusing results include familism operating as an obligation rather than affection, use of the wrong construct for measuring familism, and culture as a fundamentally interesting factor rather than an operative factor. As the authors point out, familism is still an unstable and confusing term. Nevertheless, familism can also benefit minority caregivers in other ways, such as rewards from the caregiving (Jolicoeur & Madden, 2002) and personal growth through the process (Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002). The dissertation will investigate the relationship between familism and Korean American dementia caregivers' positive attitude toward caregiving, hypothesizing that the caregivers appraise their caregiving experience more positively when they report higher

familism.

Filial Piety

Filial piety is one of the core ideas of Confucian ethics (Hwang, 1999; Yeh, & Bedford, 2003), and it is a social value that deeply influenced the parent-children relationship of East Asian population (Sung, 1997). Originally, filial piety in Confucianism contained ideas about children's responsibility to their parents, and it essentially guided offspring to recognize the care they received and respect for their aging parents (Yeh & Bedford, 2003). However, the role and content of filial piety in Asian families and society are slightly changing. Sung's (1995) study with 1,227 Korean adults and pre-adults identified two dimensions of modern filial piety, namely, behaviorally oriented filial piety (sacrifice, responsibility, and repayment) and emotionally oriented filial piety (family harmony, love/affection, and respect). The research reveals that filial piety is not just obeying parents but also having affection for them.

Yeh and Bedford (2003) proposed a modern dual filial piety model by comparing reciprocal filial piety, emotional and spiritual attending to one's parents, and authoritarian filial piety, suppressing one's own wishes and following the parents' wishes. The authors found that reciprocal filial piety has a positive effect on college and high school students' personality, including extraversion, openness, agreeableness, and conscientiousness. The

research also found that authoritarian filial piety has a negative effect on personality including extraversion, openness, and conscientiousness. The authors are convinced that reciprocal filial piety is applicable in other cultures due to its self-reinforcing element (Yeh, & Bedford, 2003). In this way, Confucianism and other Western philosophies can reinforce each other.

Cultural belief in filial piety explains a large part of the selection of main caregivers in the family decision process when a parent is ill. A spouse is more like to be the main caregiver in White culture (Janevic, & Connell, 2001). In Asian culture, however, the eldest son and his wife typically provide care to the parents in observation of Confucian values (Braun & Browne, 1998). Taking care of a demented parent has been the responsibility of the married oldest son and his wife in Korean culture as well. Even in the case where the first son and his wife do not reside with the patient, they are assumed to be the main caregivers (Youn, et al., 1999). Cultural tradition rooted in filial piety teaches that children should respect their parents and take care of their old parents (Lee & Sung, 1998). Filial piety explains the decision making process and acceptance of caregiving.

Lee and Sung (1998) studied the cultural influences on caregiver burdens of Korean American children and American adult children. Their findings suggest that the lower burden experienced by Korean Americans is related to extended family support and high filial responsibility. On the other hand, lower level of burdened experienced by American

caregivers was associated with the use of formal services and the level of gratification from caregiving. Interestingly, there was a big difference in the two populations. Over half of the Korean caregivers (55%) were daughters-in-law whereas a significant percentage of American primary dementia caregivers were daughters (78.7%). Along with underscoring the positive influence of filial piety on Korean dementia caregivers' burden, the authors pointed to the need for culturally appropriate community services to reduce caregiver burden. There is still social stigma in institutionalizing aging parents in Korea. Community services, appropriately arranged while complementing the informal family assistance, can help family caregivers to continue caring for their loved one. The dissertation will include filial piety into the measurement of acculturation in order to assess the role of filial piety in Korean American dementia caregivers' positive attitude toward caregiving.

Acculturation

When an immigrant enters a new country, some acculturation is inevitable. Attempting to keep pace with the rapid movement of globalization and increasing cross-cultural immigration, research on acculturation has been growing (Hunt, Schneider, Comer, 2004; Miller, & Chandler, 2002). Acculturation has been considered in terms of a process involving the adopting or acquiring of the language, customs, and values, and so on, of a dominant or alternative culture (Skinner, 2002). It has been a popular topic in minority aging research where social scientists are paying increasing attention to the role of culture in human

development (Hunt, Schneider, & Comer, 2004). Immigrants in the U. S. can serve as good samples for acculturation research since the country is composed of multicultural immigrants.

Early sociologist Robert Park (1914) defined acculturation according to a three-stage model--contact, accommodation, and assimilation. Contact between peoples from different cultures forces them to seek ways of accommodating each other in order to minimize conflict. Contact shapes intergroup relations between different ethnic communities. He argues that the assimilation process is progressive and irreversible (Persons, 1987), a point that is debatable.

Acculturation research was later conducted in anthropology. In the early anthropology literature, acculturation appears as a "phenomena which results when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (Redfield, Linton, & Herskovits, 1936, p. 149). Redfield, Linton, and Herskovits (1936) present three results of acculturation: (1) acceptance, where acculturation eventuates in the taking over of the greater portion of another culture and the loss of most of the original cultural heritage; (2) adaptation, where both original and foreign traits are combined well and produce a smoothly functioning cultural mosaic; and (3) reaction, where acculturation happens due to oppression or unforeseen results of the acceptance of foreign traits; contra-acculturative movements arise. The authoritative definition of the term concerns the reciprocity of both cultures, where acculturation is a product resulting from cultural exchange.

Some two decades later, the Social Science Research Council (1953) provided a more elaborate definition of acculturation:

> Acculturation is culture change that is initiated by the conjunction of two or more autonomous cultural systems. Acculturative change may be consequences of direct cultural transmission: it may be derived noncultural causes; it may be delayed, as internal adjustments following upon the acceptance of alien traits or patterns; it may be reactive adaptation of traditional models of life. Its dynamics can be seen as the selective adaptation of value systems, the processes of integration and differentiation, the generation of developmental sequences, and the operation of role determinants and personality factors (p. 974).

This revised definition mentions that cultural change can be delayed and reactive. It also describes a "dynamics" of choice concerning value systems.

According to Gordon (1964), sociologists and cultural anthropologists tend to use different, though overlapping, terms, "assimilation" and "acculturation" respectively, to describe the "process and result of ethnic meeting." Golden (1964, 1978) provides an overall assimilation model composed of seven major variables. They are cultural or behavioral assimilation (change of cultural patterns to those of host society), structural assimilation (large scale entrance into cliques, clubs, and institutions of host society, on primary group level), marital assimilation (large-scale intermarriage), identical assimilation (development of

sense of people hood based exclusively on host society), attitude receptional assimilation (absence of prejudice), behavior receptional assimilation (absence of discrimination), and, finally, civic assimilation (absence of value and power conflicts) (Gordon, 1978). Each of these steps can be understood as a dimension of the assimilation process, and they can be characterized accordingly. For example, the entrance of a foreign group into a new country can be explained by "structural assimilation," and taking on a sense of new people hood would be "identical assimilation" (Gordon, 1978). This multidimensional assimilation model can be used to measure the acculturation of racial groups based on various empirical stages.

As the studies became more psychological in orientation, attention was paid to individual differences in acculturation (Berry, 1997), since it was understood that not everyone experiences the same acculturation level even though they are in same acculturative arena. Keefe and Padilla (1987) proposed a multidimensional acculturation model containing two concepts--cultural awareness and ethnic loyalty. Cultural awareness refers to the individual's implicit knowledge of the original culture and host culture, including for example proficiency of each language, knowledge of the histories, music, norms, and values of both cultures. When individuals demonstrate more knowledge of the original culture, they are less acculturated. If they show more knowledge of the host culture, then they are more acculturated.

Ethnic loyalty is another criterion concerning acculturation, which is defined as the

self-described ethnicity of the individuals, ethnic group membership of one's friends groups, and preference of recreational things (Keefe, & Padilla, 1987). In studies with Mexican population using this model, it was shown that cultural awareness declined from the first immigrations to next generations who resided in the U. S. Ethnic loyalty, however, remained consistently high from the first generation to the next generations (Padilla & Perez, 2003). Such a finding implies that acculturation cannot be simply represented by lengths of occupation in or language proficiency of the host culture. Historical background as a foreigner in the host country, many other social and environmental conditions, and family factors all determine one's acculturation process and strategies.

Acculturation has been defined as a process rather than a product. The acculturation process involves ethnic group members being influenced, consciously or unconsciously, as a result of living within a host society (Valle, 1997). Valle (1997) thus contends that acculturation should be understood as a continuum (Figure 2.1, p.39). Some members of a specific group may be more traditional and linked to their original culture while others from the same group belong to the host society. Also there may also be bicultural group members who take both sides eclectically. Each ethnic member's acculturation process depends on his/her contextual situation and individual characteristics. It is necessary then to understand a client or a family's acculturation process as a full spectrum and identify the range variations contextually in order to make a comprehensive assessment.

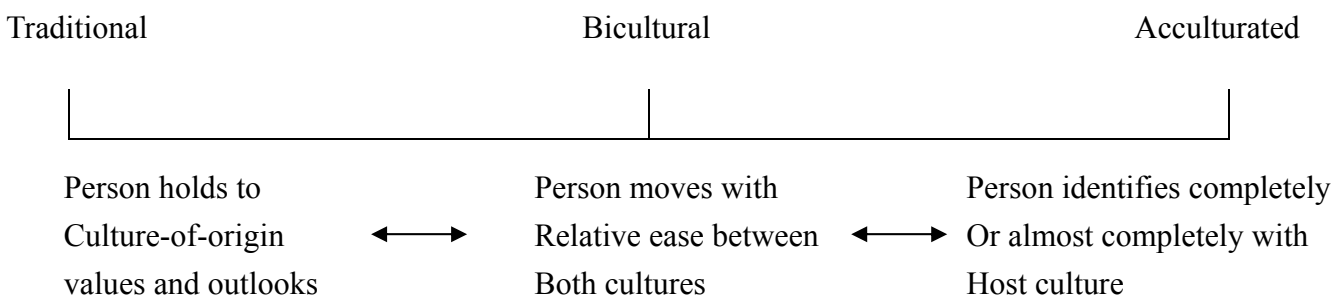


Figure 2.1: Acculturation continuum framework (Valle, 1997).

Current social and psychological theory holds that acculturation is neither linear nor unidimensional but rather multidimensional (Berry, 1997; Skinner, 2002). Skinner (2002) argued that acculturation should be understood as a negotiation between cultures. Skinner (2002) suggested that acculturation as a bicultural phenomenon is more applicable to a multicultural society since people retain aspects from their original culture while they select aspects of the alternative culture. The four forms of the multidimensional acculturation strategies model proposed by Berry (1997) (Figure 2.2, p.40) also holds that one's belonging to dominant society does not mean his/her detachment from the original culture, thus leaving the possibility for a condition of cultural pluralism. The strategies include assimilation (not wanting to maintain the original cultural identity and pursuing daily interaction with other cultures), segregation/separation (placing value on the original culture and at the same time wanting to avoid interaction with other cultures), integration (maintaining original culture with daily interactions with other cultures), and marginalization (little interest in maintaining original cultures and interactions with other cultures).

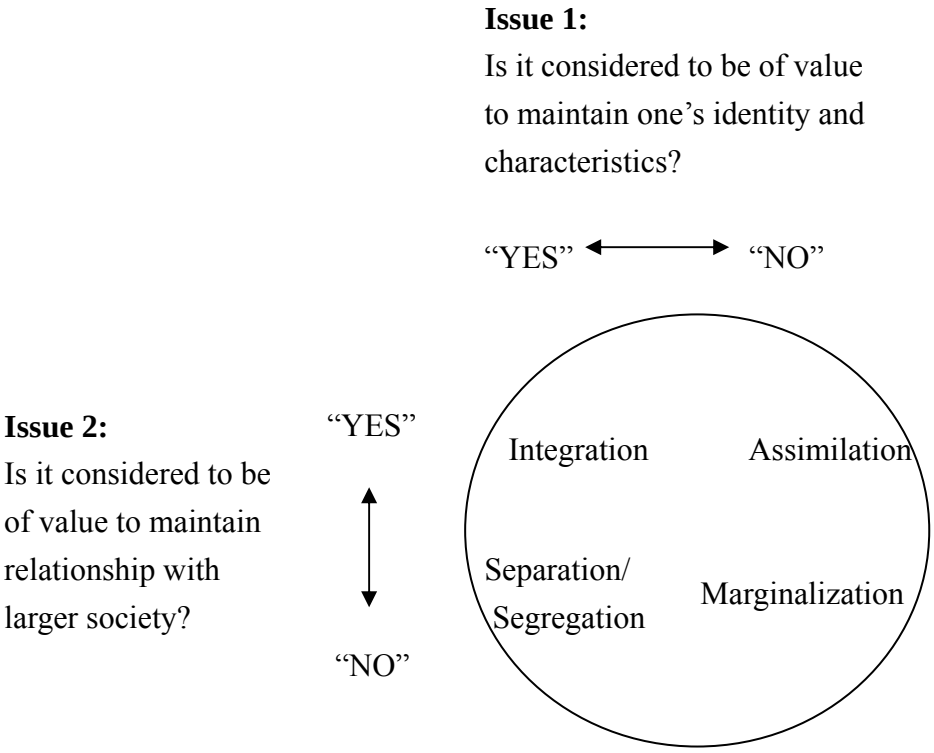


Figure 2.2: Acculturation Strategies (Berry, 1997).

Acculturation of Korean Americans

Lee, Sobal, and Frongillo (2003) compared a unidimensional acculturation model with a bidimensional acculturation model for 356 Korean Americans. The unidimensional acculturation model refers to immigrants accepting the new culture of the host society while losing their original culture. Immigrants will be somewhere between unacculturated and acculturated in the continuum. The bidimensional acculturation model explains the

biculturalism of immigrants where they can accept a new culture while retaining some of their original culture. The authors utilized Berry's (1997) four forms of acculturation model including integration, assimilation, segregation, and marginalization.

The study found that a bidimensional model explained the acculturation of the population more completely and that unidimensional acculturation is actually a subset of the bidimensional model. The integrated group showed that they have contact with a Korean network and activities while they participate in an American network and activities. Specifically, 1.5 generations (who were born in Korea but moved to the states at an early age) or 2nd generation Korean Americans showed that they are more assimilated into U.S. culture. These groups were more comfortable with American culture while segregated groups did not prefer American cultural domains. All groups, however, exemplified some bicultural aspects. This study showed that the age of immigration and American formal education are important factors determining one's acculturation. People who were younger, have more formal American education, and never married are more assimilated. The integrated and segregated groups were older, married, and were working but the integrated group immigrated to the states at an early age (Lee, Sobal, & Frongillo, 2003).

Evidence of the acculturation of Korean Americans is found in their living style, preferred language, and dietary behavior. In Lynn, Kang, and Ludman's (1999) comparison study with 200 Koreans and 200 Korean American elders, 77.5% of the Korean American

elders indicated they changed their food habits after immigration. Korean Americans elders consumed western style breakfasts, including coffee, toast, and milk, significantly more frequently than Korean style ones. Their acculturation was also revealed in their living style, for example, smaller household size. Korean American samples also listed daughter-in-law less frequently as a food purchaser and preparer. At the same time, they presented Korean dietary patterns, such as high consumption of Kimchee and rice daily, which illustrates Korean American elders' bicultural living patterns.

Acculturation and Caregiving

Acculturation is an essential part of immigration. We know that immigration can produce constant stresses in the daily life of an immigrant. In Miller and Chandler's (2002) study with two hundreds former Soviet Union women in the U. S. of the relationship between acculturation, resilience, and depression, it was found that immigrants were more depressed on average than U. S. citizens. Depression is in fact a common symptom appearing in other women suffering immigration stresses (Kim & Lew, 1994). Among the respondents, women who were more resilient and reported greater English usage were less depressed. The study suggests that interventions encouraging immigrants to use English and to develop their resilience can contribute to the immigrants' psychological well-being.

When the stress from acculturation combines with a chronic caregiving experience, the dynamics involving stress, culture, and a caregiver's psychological well-being can get

complicated. Jolicoeur and Madden (2002) investigated the role of acculturation in Mexican-American parent caregivers' burden, rewards, and satisfaction. Thirty-nine Mexican American caregivers, comprising both high-acculturation and low-acculturated groups, disclosed that caregiving produces not only burdens but also rewards since they can fulfill their role as a "good daughter" (p. 115). The expectation of being a good daughter was high in both groups even though there is some variance. There was, for instance, a significant difference between the groups with respect to their satisfaction with caregiving. Interestingly, less acculturated caregivers acknowledged more stress, burden, and less satisfaction even though they fulfilled their obligations better. They also had more informal assistance in their family network compared to the less acculturated caregivers.

Researchers using qualitative analysis found a solution to the complex result whereby one quarter to one third of the less acculturated caregivers could not recognize 'satisfied with…'. For them, providing caregiving to parents is simply part of being a child and not something that necessarily generates personal satisfaction. The less acculturated caregivers disclosed that they experience isolation and low-self esteem but were not dissatisfied with their new lives in the U. S. The researchers suggested that their low satisfaction seems to be due to a lack of integration into dominant society as well as caregiving demands (Jolicoeur & Madden, 2002).

Mental health of minority family caregiver can be explained their level of

acculturation. Coon et al. (2004) found that more acculturated Latina dementia caregivers showed higher income, education, and better overall self-rated health. Interestingly, however, less acculturated Latina caregivers showed more positive appraisals to their dementia caregiving experience compared to the more acculturated counterparts despite of the limitations they have. They researchers argued that the within group heterogeneity should not be ignored considering the effect of culture and acculturation on minority dementia caregivers' mental health.

Minority dementia caregivers are resilient. They manage their jobs as a caregiver and a societal man in foreign country. They know how to benefit from their own culture. Jones, Zhang, Jaceldo-Siegl, and Meleis (2002) described the experience of forty-one Asian American caregivers and the skills the caregivers use to manage caregiving challenges. Most of the caregivers in this study used a family-connected approach in a caregiving context. The caregivers indicated that they live with two sets of standards, deriving from the original culture and American culture. In this potentially conflicted process, they experience an adjustment of both values and cultures. The attempt to resolve cultural conflicts often requires careful interactions with family members. The researchers described the process as a "calibration," or a negation of the expected level of care in each culture. The immigrant caregivers undertake calibration in order to achieve balance between two culturally different roles and ultimately to create a new identity. The Asian American providing care for their

parents indicated that they experienced personal growth and found meaning from the caregiving experience. The positive outcome worked as a significant reinforcement for them to continue the care for their parents. At the same time, culturally inappropriate community services and language problems were barriers for them to adopt community assistances (Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002).

Lee and Farran (2004) conducted a transcultural study examining the depression levels of one hundred Korean dementia caregivers, fifty-nine Korean American dementia caregivers, and seventy-eight Caucasian dementia caregivers. First they confirmed that the three dementia caregiver groups were depressed, scoring clinically higher than the cutoff point of 16 on CES-D (Center for Epidemiologic Studies-Depression Scale). Among the interesting findings of the study were that Korean caregivers were most depressed and that the wife caregiver group, across the three populations, was more depressed than daughters or daughters-in-law group. The authors interpreted Korean dementia caregivers' depression as due to social sanctions or expectations that the caregivers care for their parents despite a lack of social and governmental support. Wives' depression can be understood to be related to their aging factor and declining physical health. Lee and Farren (2004) assumed that Korean American caregivers can feel less burdened when they acknowledge that there is an option to place their parent into a nursing home.

Koreans accept western culture openly while keeping their original culture. In most

of the Korean American families, Korean born parents (1st generation) and American born children (2nd generation) or Korean born children (1.5th generation) live between two cultures, where two languages (Korean and English), two cultures, and different acculturation levels conflict (Kim, 1996). They have been acculturated in some ways. In Youn et al.'s (1999) comparison of Korean, Korean American, and White caregivers' familism, Korean caregivers presented much higher familism than White and Korean American samples. This result that implies Korean American dementia caregivers have been acculturated into the U. S. norm. Their living arrangement preference also is evidence of their acculturation. For example, many invited Korean parents, who are invited by their children to the U.S., prefer living separately from their married children while maintaining a close relationship with their children (Kim & Kim, 2001; Pyke, 2000). Kim and Kim (2001) described the new phenomenon as "intimacy at a distance." Korean American adult children can practice both Korean and American cultural traits with the terms of this new relationship.

Korean Americans are more likely to be Christian and adopt western values even though their life style, such as food preference, adheres to traditional Korean ones. Therefore, the Korean American daughters-in-law experience a discrepancy between the two cultures. They can view the caregiving role as burdensome work and not their only job while also respecting the original filial responsibility. Without clear definition and an account of the appropriate historical and sociocultural influences on their caregiving context, their

psychological well-being cannot be measured properly. As Hunt et al. (2004) argued, including acculturation into health research with minority population should be "more than stereotypes wrapped in a cloak of scientific jargon" (p. 982).

Positive Aspect of Dementia Caregiving

Resilience and Benefit Finding

Despite psychosomatic and negative outcomes that may accompany providing dementia caregiving, the caregivers also display resilience throughout the long journey. Resilience, the ability to overcome adversity, is an innate human characteristic. According to Rutter (1987), human resilience is the "positive pole of individual differences in people's response to stress and adversity, as well as hope and optimism in the face of adversity" (pp. 316–317). Greene and Conrad (2002) specified resilience as a biopsychosocial-spiritual phenomenon that occurs across the life course. Resilience involves competence in daily life. Dementia caregivers who continuously must shift their role and adapt to a changing family system as their loved one's disease progresses are resilient.

The caregiving research paradigm has shifted its focus to the positive aspects of dementia caregiving (Allen, Kwak, Lokken, & Haley, 2003; Boerner, Schulz, & Horowiz, 2004; Roff, Burgio, Gitlin, Nicolas, Chaplin, & Hardin, 2004). Kramer (1997) stated the reasons that positive aspects of caregiving should be investigated: (1) caregivers have

reported gains and they want to talk about them; (2) clinicians can work more effectively understanding positive aspects of the experience; (3) older adults may receive increased quality of care; and (4) theorists can build on concepts related to a caregiver's adaptation and psychological health (Kramer, 1997). Furthering the argument for a strengths perspective, Saleebey (2002) contended that every individual, family, and community has their own capacity to grow. Negative experiences and illnesses are also part of an individual's culture and personality, and they can be a resource for change. The strengths perspective encourages practitioners and researchers to focus on clients' strengths rather than on problems, fostering their resilience and competence (Saleebey, 2002).

Finding Meaning

Research findings generally show that, through caregiving, women can gain a sense of self-worth and mastery, qualities associated with greater family cohesion and marital satisfaction (Martire, Stephens, & Franks, 1997). Caregivers also reported that they valued positive aspects of relationships with their impaired family member. In addition, they appreciated their own feeling of confidence that giving care provided them (Farren, Miller, Kaufman, Donner, & Fogg, 1999). For example, Hepburn et al. (2002) conducted a qualitative study with 132 spouse caregivers regarding their experiences in dementia caregiving. Caregivers talked about the lessons they gained from the role: enhanced knowledge of self, "carpe diem" (seize the opportunity), faith, family unity, idiosyncratic

meaning, acquisition of skill, value of humor, acceptance, and expression of internalized belief. The caregivers found a transformed inner-self through the caregiving process and even received benefit from it.

In another qualitative study by Paun (2003), dementia caregivers disclosed that they noticed change, took charge, adjusted, or coped. They also made sense of their situation and looked into their future, projecting strength, determination, and survival through the caregiving process. Their interpretations of being a caregiver for their loved one represented their personal growth. The caregivers decided not to be a victim and took charge of the caregiving situation.

Another study by Noonan and Tennstedt (1997) tested the contribution of finding meaning in the caregiving situations of 131 informal caregivers. Caregivers find meaning when they come to terms with their situation. Finding meaning in caregiving had a positive effect on self-esteem. Alternatively, a feeling of overload or of having too many responsibilities, which could lead to caregiver stress, was the best predictor of caregiver depression and low self-esteem. Caregivers who more actively sought meaning in their caregiving activity reported greater well-being. This suggests that it is important for the practitioner to explore factors related to survivorship and to learn from the dementia caregiver what he or she perceives as positive coping strategies (Noonan & Tennstedt, 1997).

Cohen, Colantonio, and Vermich (2002) also conducted research on positive aspects

of caregiving and reported that positive feeling about caregiving is negatively related to depression and burden or poor health. Two hundreds and eleven caregivers (73%) answered that they could find a positive aspect of caregiving. Specific positives included companionship (22.5%), a sense of fulfilling/rewarding (21.8%), enjoyment (12.8%), and sense of duty and obligation (10.4%). The research outcomes support the necessity of comprehensive research and social work intervention that take into account positive aspects of caregiving along with negative views of caregiving.

How does the dementia caregiver survive the long journey? Pierce, Lydon, and Yang (2001) argued that greater internalization (e. g., autonomy and self-determination) and identification with dementia caregiving can produce caregivers' enthusiasm to care for their loved ones. Such enthusiasm may reduce the caregiver's appraisal of threats in problematic situations and enhance his or her general well-being. Although this research used a small sample size (37 primary caregivers and 13 nonprimary caregivers), it provided significant insights into how a dementia caregiver persists in the sometimes burdensome process.

Coping Styles

To better understand how a dementia caregiver persists, it is important to examine coping styles. Dementia caregivers present different types of coping styles and develop them through the caregiving process. Lazarus and Folkman (1984) distinguished problem-focused coping, which is managing the problem within the stressful environment, from emotion-

focused coping, which is adjusting the emotional response to the crisis. Both coping strategies have complex relationships to each other and can be used either simultaneously or sequentially (Lazarus & Folkman, 1984).

A study by Garity (1997) researched seventy-four dementia caregivers' coping styles and their relationship to resilience. This study affirms the importance of proactive coping in enhancing dementia caregivers' resilience in the caregiving context. Problem-focused coping strategies include planning, creating, and implementing an action plan, and developing different solutions to each situation. Emotion-focused strategies take into account caregivers' need to express anger. Confrontive styles of coping in which the caregiver may express negative feelings towards the care recipient were also found to be beneficial. Emotion-focused coping strategies involved seeking social support, achieving positive appraisal, confronting oneself, and distancing. The authors concluded that the dementia caregivers who made action plans and followed them were more resilient. The results also showed that the caregivers who tried to see the bright side of the situation were more resilient. On the other hand, the caregivers who adopted the emotional coping skills of trying to escape or avoid the situation, wishing the situation would disappear, or increasing their drinking and smoking had a lower resilience score (Garity, 1997).

An Existential Perspective

Many dementia caregivers overcame their difficult situations and even went beyond

them, being satisfied with being a caregiver for their loved one and receiving benefits from it. However, Farren (1997) has argued that more can be learned by broadening the stress or adaptation model by combining it with an existential perspective: existential theory allows for an understanding of a "human's ability to discover and create meaning through transcendence and transformation of dementia caregiving experience" (p. 255).

Yalom (1995) discussed existentialism in terms of human beings' struggles with the ultimate concerns of existence, such as "death, isolation, freedom and meaningless" (p. 91). He went on to say that humans are essentially "meaning seeking creatures" (p. 91), fighting in a world which does not have meaning. He emphasized that including existential factors, such as acknowledging that life is sometimes unfair and recognizing one's ultimate responsibility in a situation regardless of others' help, was an incredible therapeutic tool in caregiving situations (ibid.). The existential perspective also allows the caregiver to provide the practitioner with their subjective experiences and context. The existential perspective can thus give the practitioner answers to why some caregivers grow through the process, while others do not experience the same benefit.

Burden and Gain

Burden and gain in dementia caregiving are not simply opposites. Narayan, Lewis, Tornatore, Hepburn, and Corcoran-Perry (2001) argued that positive and negative aspects of dementia caregiving can coexist. Qualitative interviews with the fifty caregivers supported

the coexistence of the two aspects of caregiving. Fifty-eight percent (58%) of respondents disclosed that they experienced "self-fulfilling and affirming" experiences during caregiving, with the same percentage undergoing "losses and difficulties" (p. 27). In addition, positive aspects of caregiving were significantly related to the caregiver's competence. The authors provided a holistic viewpoint on dementia caregiving research, moving from a pathologic perspective, a focus on burden and harm, to personal growth and benefit-finding through the caregiving experience.

Chappell and Reid (2002) also claimed caregivers can experience burden while they maintain high to adequate levels of well-being. The authors suggested that dementia caregivers' quality of life can be enhanced even though they may suppress feelings of caregiving burden. They also found that positive and negative aspects of dementia caregiving can coexist with social support directly related to well-being and behavioral problems a main determinant of caregiver burden. Their research confirms the necessity of a holistic view point encompassing both the positive and negative aspects of caregiving.

Research Limitations

The body of research on gain and positive aspects of dementia caregiving is still growing. However, there are methodological issues. Many researches depend on convenience samples and cross-sectional data (Kramer, 1997). This leaves open questions concerning the direction of causality among stress, subjective appraisal, and coping. In addition, there are

several operational terms for positive aspect of caregiving including satisfaction (Martire, Stephens, & Franks, 1997), gains (Kramer, 1997), meaning making (Farren, 1999), benefit finding (Hepburn et al. 2002; Rapp et al., 1998), uplifts (Pinquart, & Sorensen, 2003), and reward of meaning (Cartwright, Archbold, Stewart, & Limandri, 1994).

Even though there are some limitations in the current research on positive aspects of dementia caregiving, they provide important insights for researchers and social work practitioners to expand their understanding of caregiving. Utilizing a strengths-based perspective, social work practitioners can assess the positive aspects of caregiving and implement interventions to enhance dementia caregivers' well-being. Researchers, moreover, can investigate the characteristics of dementia caregivers who benefit from the caregiving experience and thereby contribute to the further understanding of family dynamics.

Positive Aspect of Dementia Caregiving among Korean Americans

As mentioned above, relatively little is known regarding the psychological well-being, especially the positive aspects of caregiving, of Korean American dementia caregivers. Lee, Farren, Tripp-Reimer, and Sadler (2001) assessed the cultural appropriateness of Farren's Finding Meaning Through Caregiving Scale (FMTCS) with five Korean caregivers and five Korean American caregivers. The FMTCS measures the finding of meaning through caregiving from an existential point of view. The scale is composed of three subscales, including loss/powerlessness, provisional meaning, and ultimate meaning. Most of the items

of FMTCS appear to be applicable to Korean samples, with the exception of some questions on loss/powerlessness and provisional meaning.

Although this study treated Korean and Korean American caregivers interchangeably, an approach which limits the use of the results for this dissertation research, interview results nevertheless provide a cultural picture of positive aspect of caregiving. Korean caregivers shared that they were "glad to fulfill their responsibilities or obligations" (p. 24) and appreciated "their financial and physical ability to provide care for their relatives" (p. 25). The study results also furnished interesting cultural information concerning Korean and Korean American dementia caregivers' positive experiences of caregiving, which were not measured by the FMTCS.

Among Korean daughters-in-law, filial expectation was clearly dominant in their ways of finding meaning, which include the "importance of teaching children" (p. 25) to care for elders and ways to accept situations by providing caregiving to their parent-in-law. They also mentioned the importance of "feeling proud of oneself in relation to others" (p. 25), a statement that implies they feel rewarded when they feel confident in front of their husband's siblings by providing care. This study demonstrates that Korean and Korean American dementia caregivers find meaning through caregiving not simply within an individual context. The authors argued that Korean and Korean American caregivers discover meanings within an interpersonal context, including such values as unity of family and a value of harmony in

family network.

The literature review section summarized factors influencing Korean American dementia caregivers' psychological well-being and positive attitude toward caregiving. Although the study of dementia caregivers' mental health is growing, it still tends to miss two significant components, namely the positive aspects of both caregiving and culture. Much research considers caregiving simply in terms of a depressive experience and investigates the negative aspects of it. Minority caregivers are not fully included in caregiving research, and thus their cultural situation does not receive adequate attention despite its extensive effect. Therefore, there is a need to investigate the positive aspect of dementia caregiving. Moreover, more research should investigate minority caregivers' culture and their well-being.

CONCEPTUAL FRAMEWORK

Generally, stress and coping models in the caregiving area contain the following factors, as will the dissertation research: (1) contextual variables, such as gender, age, relationship to the care receiver, (2) stress variables, such as the care receiver's problem behaviors, and amount of caregiving, (3) a caregiver's appraisal of the caregiving situation as demanding or satisfying, (4) potential mediators, such as social support, and coping styles, and (5) the outcome from the caregiving, such as emotional distress, psychological and physical well-being (Knight, Robinson, Longmire, Chun, Nakao, & Kim ,2002; Lawton, et al., 1990; Pearlin, Mullan, Semple, & Skaff, 1990; Yates, Tennstedt, & Chang, 1999). This study will focus on factors contributing to Korean American dementia caregivers' attitude toward caregiving, including stress factors, social supports, and cultural factors.

This study adopted original ideas from Lawton, Moss, Klebean, Glicksman, and Rovine's (1991) two factor model of caregiving appraisal of psychological well-being (see Figure 2.3) and Aranda and Knight's (1997) sociocultural stress and coping model (see Figure 2.4). Most of the dementia caregiving research does not pay adequate attention to the positive aspects of caregiving. The two factor model was chosen because it acknowledges the existence of positive aspect of caregiving along with negative aspect of caregiving. The sociocultural stress and coping model is adopted because it sees ethnicity as a structural status variable and also a factor affecting each step of the stress and coping model.

Two Factor Model of Caregiving

Lawton, Moss, Kleban, Glicksman, and Rovine (1991) (figure 2.3, p. 65) created a two factor model of caregiving appraisal of psychological well-being based on Lazarus and Folkman's (1984) stress and coping model. Originally, Lazarus and Folkman (1984) conceptualized a transactional, process-oriented model comprised of three types of cognitive appraisal: (1) primary, (2) secondary, and (3) reappraisal. Primary appraisal includes judgment of the unexpected onset of a condition that is perceived as "irreverent, benign-positive, or stressful" (p. 32). Secondary appraisal refers to evaluation of possible coping strategies within the perceived context. Reappraisal is a changed appraisal when new resources are provided or perceived within one's environment. Personal factors, such as commitment and belief, and situational factors, including novelty, predictability, event uncertainty, and timing of the stressful event, determine the appraisal process. Lawton et al. (1991), however, simplified the appraisal process in their two factor model. They presented primary appraisal and secondary appraisal of stress as one general construct. In their model, caregiving appraisal refers to "all cognitive and affectional appraisals and reappraisals of the potential stressor and the efficacy of one's coping effort" (p. 61).

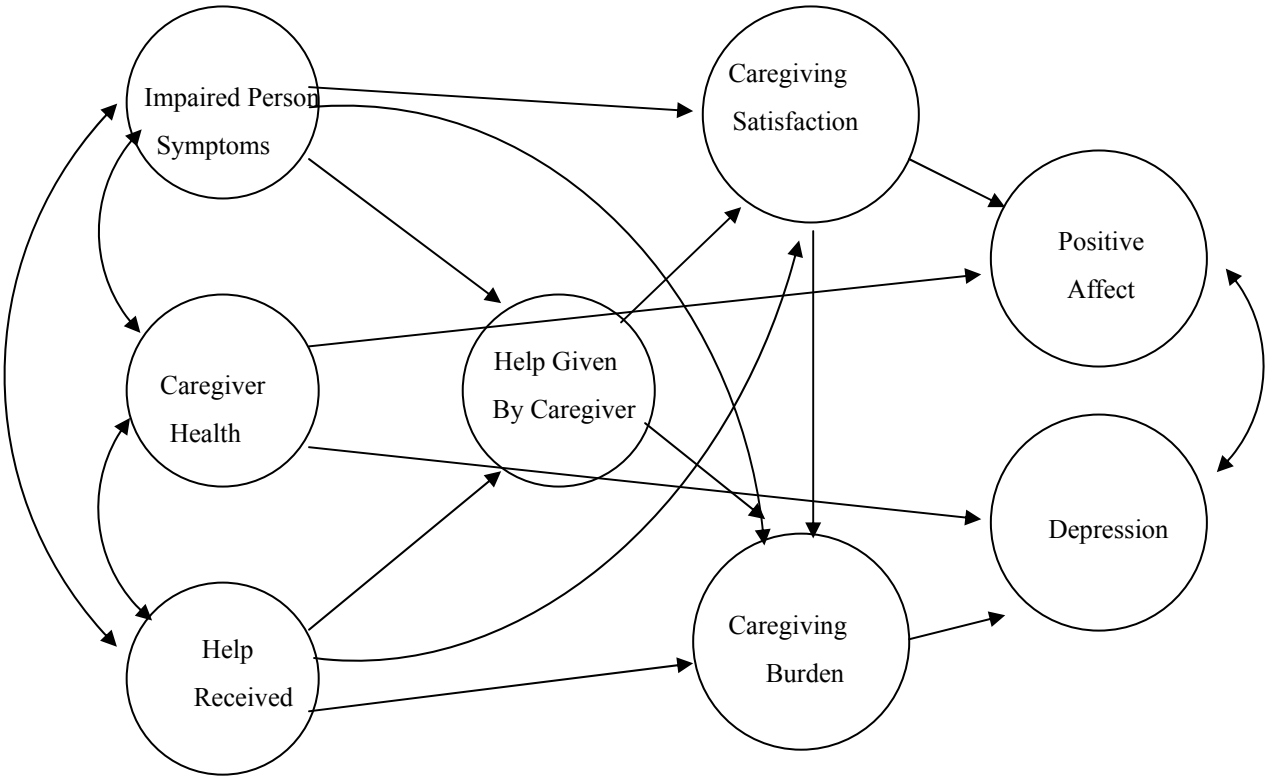


Figure 2.3: Caregiving model for spouse and adult child caregivers (Lawton et al., 1991).

Lawton et al. (1991) specified that negative affect and positive affect in caregiving are different from each other and both concepts are essential for a comprehensive understanding of psychological well-being. They also pointed out the importance of appraisal in a caregiving model. Furthermore, they argued that caregiving appraisal is composed of two important elements: (1) caregiving satisfaction and (2) caregiving subjective burden. Caregiving satisfaction represents "subjectively perceived gains from desirable aspects of, or positive affective returns from, caregiving" (p. 182). Subjective caregiving burden is the "perception of psychological distress, anxiety, depression, demoralization, and generalized

loss of personal freedom attributed directly to caregiving" (p. 182).

The central feature of this model is that caregiving satisfaction leads to positive affects of caregiving while caregiving burden causes negative affects. Most importantly, the inclusion of the positive affects of caregiving into the model provides a holistic point of view within dementia caregiving research. The strength of the model for the purpose of this dissertation is that it addresses the relational aspect of caregiving. The two factor model assumes that caregiving is a dynamic process that incorporate caregivers, care receivers, and environmental and psychological factors (Lawton et al., 1991; Yates, Tennstedt, & Chang, 1999).

Lawton et al. (1991) tested the two factor model of caregiving appraisal and psychological well-being with 285 spousal caregivers and 244 children caregivers. With the assumption that there would be a coexistence of positive and negative aspects of caregiving, the researchers investigated the relationship of caregiving satisfaction to positive affect and burden to depression. The result confirmed a parallel relationship. A parallel relationship is found when a caregiver's appraisal of satisfaction is affiliated with positive affects of caregiving and appraisal of burden is correlated with depression. Within the group, the cross relationship was not as strong as the parallel relationship. A cross relationship is found when satisfaction is negatively correlated with depression and burden is negatively related to positive affect.

Sociocultural Stress and Coping Model

With the current increase of minority elders and dementia caregivers (Administration on Aging, 2004), the need for culturally competent research and practice has also been growing. Kao, Hus, and Clark (2004) argue that culture is too broad a concept and only has correct meaning within a "socio-economic-politic-cultural context" (Kao et al., 2004, p. 275). In mental health related research, culture or ethnicity has been included strictly as a structural status factor, one reflecting disadvantaged socioeconomic status. However, culture, which is a group's patterns of human behavior including customs, beliefs, and values (United States Department of Health and Human Services Office of Minority Health, 2000), affects every dimension of dementia caregiving.

According to Aranda and Knight (1997), "ethnicity and culture play a significant role in the stress and coping process of caregivers to the elderly as a result of a) a differential risk for specific health disorders and disability, b) variation in the appraisal of potential stressors, and c) the effect on stress-mediating variables such as social support and coping" (p. 343). They proposed a sociocultural stress and coping model, arguing that ethnicity and culture can change the nature of caregiving by putting minority caregivers at risk for specific illnesses (figure 2.4, p. 68).

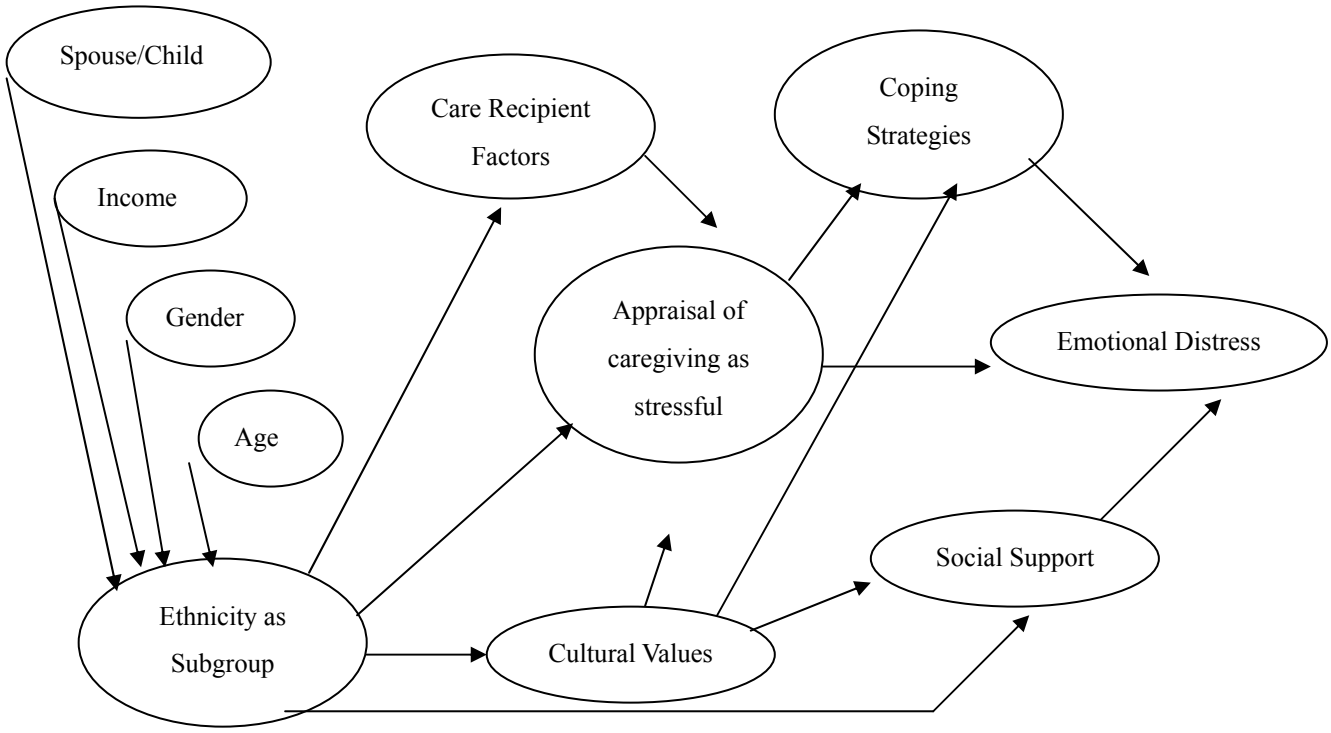


Figure 2.4: Sociocultural stress and coping model for emotional distress (Knight, et al., 2002).

Based on Aranda and Knight's (1997) argument concerning the holistic influence of culture on the caregiver stress and coping process, Knight, Silverman, McCallum, and Fox (2000) tested the sociocultural stress and coping model with dementia caregivers. They argued ethnicity as a culture is a structural status variable and also affects each step of the stress and coping model. The authors emphasized that minority ethnicity culture explains their appraisal and coping skills in the dementia caregiving context. It can happen simultaneously with different directions where culture can support caregivers and relieve burden or add more burden to caregivers. Minority caregivers, for example, may experience

less emotional distress within their cultural context. However, the cultural influence can work in detrimental ways at the same time, such as using nonproductive coping styles. This phenomenon can be found in the following study result.

Knight et al. (2000) conducted the study with 41 African American dementia caregivers and 128 non-African American dementia caregivers. The relationship of appraisal and emotional distress was confirmed when African American dementia caregivers' positive appraisal of caregiving resulted in lower emotional distress. However, the study showed multidirectional and complex relationships among culture and other factors. African American caregivers tended to use more emotional coping skills that include distancing, self-control, accepting responsibility, and escape-avoidance, rather than problem-focused (or active) coping. The emotional coping skills indirectly increased emotional distress. African American caregivers were also in poor physical health which contributed to more burden and worse mental health. This study confirms the importance of including culture as a variable in caregiving research. It also shows that the relationships among culture, contextual factors, stress factors, and appraisal of the caregiving and psychological well-being of the caregivers are complex and confounded with one another.

Knight et al. (2002) conducted a study based on the sociocultural stress and coping model with Korean, Korean American, and White dementia caregivers. They tested the role of social support and culture, measured by familism, the perceived strength of family bonds

and sense of commitment to family, on emotional distress using multivariate regression. All three caregivers groups showed different familism levels. Contrary to expectation, familism was not significantly related to caregivers' depression and anxiety in all three groups. Furthermore, social support was not related to depression and anxiety. The authors concluded that this confusing result could be explained by measuring not the amount of social support but the quality of social support caregivers receive. It is also suggested that filial piety, a core factor in Asian value systems (Hwang, 1999; Yeh, & Bedford, 2003), be included in to aid in the explanation of Asian family caregivers' culture. In the dissertation research, filial piety will be included in the measurement of acculturation.

Theoretical Model for the Proposed Study

Based on the previous research, the proposed study was guided by a conceptual model, which examines factors affecting Korean American dementia caregivers' attitude toward caregiving. Figure 2.5 provides a diagram of conceptual model which guides this research.

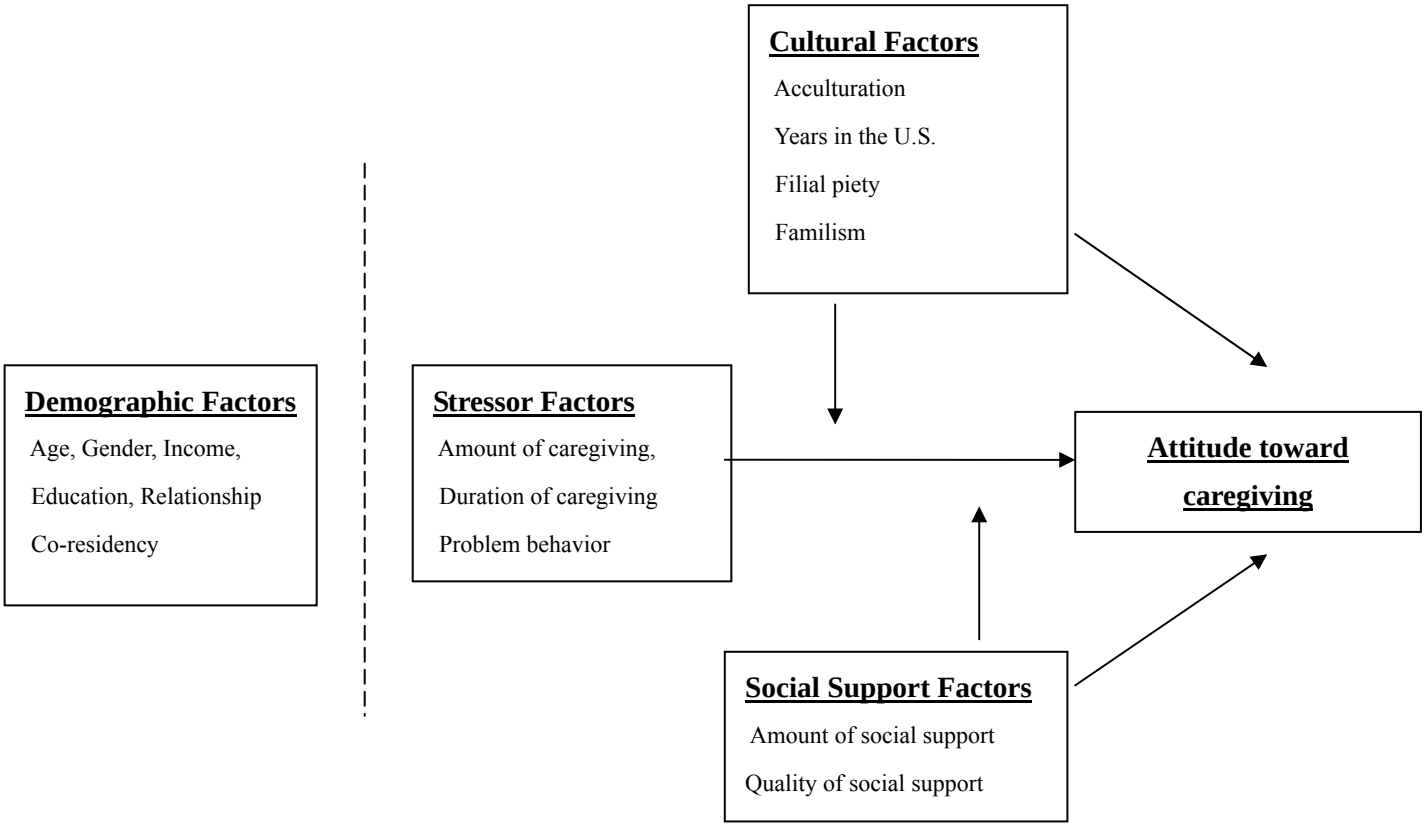


Figure 2.5: A diagram of conceptual model

Stressor factors

Research has demonstrated that objective stresses from dementia caregiving activities affect caregiver's attitude toward caregiving. In Schulz and Beach's (1999) prospective population-based cohort study with a total of 392 caregivers and 472 noncaregivers, caregivers who experienced caregiving strain had a 63% higher mortality rate than noncaregivers. Gaugler, Kane, Kane, and Newcomer's (2005) study showed that recipient's deleterious behaviors in the early stages of dementia increased burden and depression. It is hypothesized in this research that Korean American dementia caregivers will report significantly more positive attitude toward caregiving when they have less stressor.

Cultural factors

Culture plays a vital role through the entire course of dementia caregiving. In minority family, certain culture determines family dynamics and well-being of an individual and whole family member. In Aranda and Knight's (1997) account, ethnicity as a culture impacts each element of stress and coping model. Particular aspects of minority culture may explain caregiver's appraisal and coping skills in the dementia caregiving context. Familism, which is a perceived strength of family bonds and sense of commitment to family, and filial piety, which is an idea about children's responsibility to their parents, are core concepts in Korean culture. Youn, Knight, Jeong, and Benson (1999) discovered

that Korean and Korean American dementia caregivers had higher familism than White caregivers. However, Korean and Korean American caregivers presented higher burden, anxiety, and depression than their counterparts.

Some degree of acculturation into the main culture is inevitable for immigrants. It affects a caregiving family caregiver's appraisal of demanding caregiving situation and their well-being. Jolicoeur and Madden's (2002) research on the role of acculturation in Mexican-American parent caregivers' burden, rewards, and satisfaction disclosed that caregiving produces not only burdens but also rewards. The analysis showed that less acculturated caregivers acknowledged more stress, burden, and less satisfaction even though they fulfilled their obligations better. They also had more informal assistance in their family network compared to the less acculturated caregivers. In Jones, Zhang, Jaceldo-Siegl, and Meleis's (2002) research, Asian American caregivers reported that they live with two sets of cultural standards, the original culture and American culture. Most of the caregivers in their study used a family-connected approach in a caregiving context. They experienced personal growth and found meaning from the caregiving experience. The positive outcome worked as a significant reinforcement for them to continue the care for their parents. Due to limited research support and the conflicting role of culture on Korean American dementia caregiver's attitude, no directionality is posed between culture and caregivers' attitude toward caregiving. In this dissertation it is hypothesized that there is a significant relationship between cultural

factors of Korean American dementia caregivers and an attitude toward caregiving.

Social support facotrs

The positive role of social support on caregivers' psychological well-being is well-established (Chapell, & Reid, 2002; Rapp, Shumaker, Schmidt, Naughton, & Anderson, 1998). Social support is a strength that has been shown to mitigate the impact of the caregiving demand and it has been an important factor contributing to dementia caregivers' well-being across cultures. In Chapell and Reid's (2002) research, 243 Canadian caregivers showed that perceived social support was positively related to their general well-being. In a study of depression, quality of life, and perceived benefit among caregivers, Rapp, Shumaker, Schmidt, Naughton, and Anderson (1998) found that social resources constituted the most significant factor related to a caregiver's well-being. Social support is a significant buffering system among Korean immigrant. Kim, Han, Shin, Kim, and Lee (2005) showed the Korean Americans' negative affect of stress on depression was significantly mediated by social support.

Therefore, this dissertation research will include level/type of social support within the model in order to test the role of social support on Korean American caregivers' attitude toward caregiving. It is hypotheses that Korean American dementia caregivers will report significantly higher score on attitude toward caregiving when they have greater social support.

Interaction effect of acculturation between social support and attitude toward caregiving

According to Lee, Koeske, and Sales (2004), social support significantly moderated the effect of the acculturative stress, which is a stress induced by a process of adaptation to a host culture, on Korean American students' mental health. Interestingly, the moderating effect of social support on mental health was found only within the highly acculturated group. With an assumption of the interaction between acculturation and social support, the moderating effect of acculturation between Korean American dementia caregivers' social support and their attitude toward caregiving will be tested. It is hypothesized that effect of social support on Korean American caregiver's positive attitude toward caregiving will be greater in more acculturated group than in less acculturated group

Demographic factors

Since there is extensive research done on the relationships between demographic variables and a caregiver's attitude toward caregiving, the effect of the demographic factor will be controlled in this study.

This dissertation will investigate the difference between spousal caregiver's and children caregiver's psychological well-being. A difference is expected between spousal caregivers and adult children caregivers because many research studies show that adult children caregivers experience more negative aspect of caregiving than spousal caregivers

(Cahill, 1997; Coen, Swanwick, O'boyle, & Coakley, 1996). Therefore, spousal caregivers will report significantly higher scores on the measure of attitude of caregiving than child caregivers. In Lawton et al.'s (1991) study, for example, the psychological well-being of adult children caregivers, unlike spousal caregivers, was very sensitive to the amount of care they provided and the extent to which there was an appraisal of the burden. The authors argued that the different results for the two groups could be explained by their different perceptions of caregiving. For spousal caregivers, a caring husband/wife is part of an experience of marital commitment and human development. Therefore, the objective caregiving workload does not impact the spousal caregiver's appraisal of burden and psychological well-being. For children caregivers, however, caring for a parent is an extra activity in addition to current roles. Therefore, they are more burdened, and their psychological well-being is challenged by the amount of caregiving workload (Lawton et al., 1991).

CHAPTER III

METHODOLOGY

The Study Design

Research Questions and hypotheses

The dissertation design addresses the following questions:

1) Do Korean dementia spousal caregivers have a more positive attitude toward caregiving than do child caregivers?

2) Is there an interaction effect between the level of acculturation and social support on Korean American dementia caregivers' attitude toward caregiving?

3) To what extent is a Korean dementia caregiver's attitude toward caregiving influenced by stressor factors, social support factors, and cultural factors, controlling for demographic factors?

To answer the three research questions, the following hypotheses were created:

H1. Korean American spouse caregivers will report significantly higher scores on the measure of attitude of caregiving than Korean American child caregivers.

H2. Effect of social support on Korean American caregiver's positive attitude toward caregiving will be greater in more acculturated group than in less acculturated group.

H3. Korean American dementia caregivers will report significantly higher scores on attitude toward caregiving when they have less stressor factors, controlling for demographic factors.

H4. Korean American dementia caregivers will report significantly higher scores on attitude

toward caregiving when they have greater social support factors, controlling for demographic factors and stressor factors.

H5. There will be a significant relationship between cultural factors of Korean American dementia caregivers and an attitude toward caregiving, controlling for demographic factors, stressor factors, and social support factors.

Sampling procedure and participants

For purpose of this study, a Korean American dementia caregiver was an individual who was taking care of a community dwelling demented spouse, parent, or other family member. Because of practical limitations, a convenience sample of Korean American dementia caregivers was obtained from various sources. A total of 85 Korean American dementia caregivers were be recruited through various Korean American centers, Korean Adults Health and Day Care Centers (ADHC) in Los Angeles, and churches in the U.S. The senior centers include Asian American Family Service in Houston, St. Barnabas Senior Center of Los Angeles, and Korean American Senior Center in Chicago. The ADHCs include Bell Christian Home ADHC, Commonwealth ADHC, Los Angeles ADHC, Sarang ADHC, Sherman way ADHC, Sunnyhills ADHC, Vermont ADHC, Western ADHC, Wilshire ADHC, and Young Again ADHC.

Formal letters and e-mails requesting permission to conduct a survey with Korean dementia caregivers were sent to the possible agencies in the U.S. which serve Korean American dementia patients and their families. Eighteen agencies were contacted and thirteen

of them agreed to participate in the research. The agencies provided the researcher the list of possible respondents and their mailing addresses once they contacted potential caregiving participants and obtained the caregivers' voluntary agreement on being part of this research.

Participants completed the survey at Korean American senior centers or wherever they felt comfortable. The researcher informed the respondents that the data collected during the study did not contain any identifying information that could associate the participant with it. The respondents were also informed that they could refuse or stop participating in the study without penalty or loss of benefits to which they are otherwise entitled. A copy of the consent form was provided to the respondents. A list of Korean social service agencies was available in case there was a need for follow up. Participants were involved for approximately 30 minutes to 1 hour to answer the survey questions. Surveys were also mailed with returning envelopes to the participants who preferred mail survey. They mailed their completed survey to the principal investigator using the self-addressed return envelops. They received $10 Wal-Mart gift certificate as a compensation for their time. The researcher contacted the possible sites beginning in July, 2006. The data was collected from December, 2006 until May, 2007.

The Study Measurements and Definitions of Variables

Definition of all variables in this study is summarized in Table 3.1 (p. 90). All measurements were translated into Korean by the principal investigator and back-translated it into English by another Korean doctoral student who is specialized in gerontology. A Korean speaking social worker and native Korean speaker who is not from social work discipline reviewed the translation of the measurements. Items were modified by the reviewers for conceptual equivalence and metric equivalence. Conceptual equivalence infers observed behavior has same meaning in other cultures and metric equivalence means that observed indicators relate in the same way across cultures (Rubin, & Babbie, 2001).

Background factors

Background factors in this study included the caregiver's age (in years), gender, annual household income, education, relationship to a care receiver (Coding 1=Spouse, 2=daughter, 3=daughter in law, 4=son, 5= other), and co-residence (1=Yes, 2=No). These are the control variables in this study.

Stressor factors

Stress is conceptually defined as "a relationship between person and environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus, & Folkman, 1984, p.19). Stressor factors included a care receiver's problem behaviors, amount of care a caregiver provides, and duration of caregiving. A care

receiver's problem behaviors were measured by the 24-item Revised Memory and Behavior Problems Checklist (RMBPC; Teri et al., 1992). The RMBPC is caregiver-report measure of care receiver's current behavioral and cognitive disruption. The behaviors and cognition measured fall into three categories: (1) depression, (2) disruption, and (3) memory-related problems. Respondent can report the amount of problematic behaviors (from never occurs to occurs daily or more often) and their reaction to these behaviors (from not at all to extremely) on a likert scale. The RMBPC reports good reliability (α= .84 for frequency of problem behavior, α= .90 for caregiver reaction). The subscales also have good concurrent and discriminant validity (Teri et al., 1992). In this research, only the occurrence of the care receiver's problem behaviors was used. For each items, caregivers indicated whether a care receiver's behavior and memory problems had occurred within the past week.

The amount of care a caregiver provides was measured by asking a question about how many hours caregiver spent directly caring for or supervising the care receiver per day.

Duration of caregiving was measured by a question that asking how many years a caregiver had taken care of the care receiver.

Social support factors

Social Support is conceptually defined as the functions done for the individual by significant others, such as family members, friends (Thoits, 1995), neighbors, and community members. The dissertation measured Social Support with two modified instruments that

examine specific help received and satisfaction with received support. The amount of support received was measured by the modified Lubben Social Network Scale (LSNS; Lubben, 1988), which was originally composed of questions related to family network, friends networks, confident relationships, helping others, and living arrangements (e.g., How many relatives do you see or hear from at least once a month?). Only family networks, friend networks, and confident relationships was used for this dissertation research. The LSNS itself is a measurement modified for older adults based on Berkman-Syme Social Network Index (1979). The original LSNS measurement presents good reliability (α= .70) with 1,037 California seniors (Lubben, 1988). Lubben et al. reported good face validity and concurrent validity, with r=.21 ($p<.001$) correlation with Life Satisfaction Index (LSI). The LSNS also has significant relationship with Belloc-Breslow checklist on health habits (r=.13, $p<.001$) and hospital use (r=.10 ($p<.01$).

Satisfaction with social support was measured by three items selected to measure tangible, emotional, and informational social support (Krause, & Markides, 1990) (e.g., "Overall, how satisfied in the last month have you been with the suggestions, clarifications, and sharing of similar experiences you have received from others?"). The response option for amount of social support ranged from 0 (none) to 5 (nine or more), or 0 (less than monthly) to (daily). Response option of satisfaction with social support ranged from 0 (never) to 3 (very). The panel of experts participated in testing the validity of the modified social support scale.

Dr. Roberta Greene and Dr. Gayle Acton who have extensive research background on social support and caregiving research reviewed those measurements. Both of them agreed on that the modified instruments measure social support conceptually. The reliability of the social support scale were tested with twenty Korean American seniors at Houston Korean American Senior. Most of them were born in Korea and some of them were caregivers to their spouses or grandchildren. The average age of seniors was 65 years old. The cronbach alpha of the modified social support measurement on the amount of social support and quality of social support were .81 and .83, respectively.

Cultural factors

Cultural factors were composed of four variables, level of acculturation, the years lived in the U.S., familism, and filial piety. Acculturation is conceptually defined as a process which involves adopting or acquiring the language, customs, and values, etc. of a dominant or alternative culture (Skinner, 2002) while maintaining one's original culture. Due to complexity and the multidimensionality of acculturation, current measurements on acculturation created by other researchers did not meet the specific need of this research on dementia caregivers. For example, Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn, Richard-Figueroa, Lew, & Vigil, 1987) measures several important construct on acculturation, such as language preference and food preference, etc. However the scale includes several redundant questions on same construct. Moreover, it was developed to measure Asian

students' acculturation so some questions are not relevant to adult caregivers. Short Acculturation Scale for Hispanics (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987) measures acculturation succinctly compared to Suinn-Lew Asian Self-Identity Acculturation Scale. However, it misses an important question on respondent's self-evaluation on his/her acculturation level. Therefore, the principal investigator had created a questionnaire to measure Korean American dementia caregiver's level of acculturation.

The List of questions on acculturation was based on the Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn, Richard-Figueroa, Lew, & Vigil, 1987) and a Short Acculturation Scale for Hispanics (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987). Based on these scales and a review of the literature the acculturation questions addressed food preference (e.g., What is your food preference?), preferred language (e.g., What language do you generally speak?), peer preference (e.g., Who are your close friends?), and respondent's self-rating of acculturation (e.g., How do you rate your acculturation?). A question on length of stay in the U.S. (e.g., How many years have you lived in the United States?) was also included in the cultural factor questions to investigate the effect of duration of being in the U.S. on the caregivers' attitude toward caregiving.

The questions on filial piety were also included to measure Korean caregivers' culture. They were based on Sung's (1995) test results of measures and dimensions of filial piety in Korea. Sung's result showed that filial piety among Koreans is two dimensional: behaviorally

orientated and emotionally orientated. Behaviorally oriented filial piety is related to sacrifice, responsibility, and repayment. For the sake of parsimoniousness, two questions were chosen from each dimension. Because the factor loading was highest for sacrifice, it was chosen as a factor to address in the dissertation (factor loading= .792). Sung found that emotionally oriented filial piety was related to family harmony, love/affection, and respect. Because the factor loading was highest for respect, it was chosen as a factor to address in the dissertation (factor loading= .563). Response option of filial piety ranged from 0 (strongly disagree) to 4 (strongly agree). The panel of experts participated in testing the validity of the modified acculturation scale and filial piety scale. Dr. Yolanda Padilla and Dr. Rowena Fong who have extensive research background on culturally sensitive social work reviewed those measurements. Both of them agreed on that the modified instruments measure acculturation and filial piety conceptually. The reliability of the acculturation scale and filial piety scale were tested along with the social support measurement. The cronbach alpha of the acculturation and filial piety measurements were 0.7 and 0.4, respectively.

Familism is defined as the perceived strength of family bonds and sense of commitment to family (Luna et al., 1996). Familism was assessed by Familism Scale (Bardis, 1959), a 16- item scale that was designed to measure ideal-typical familism which includes a strong in-group feelings, emphasis on family goals, common property, mutual support, and the desire to pursue the perpetuation of the family (Bardis, 1959b). Response option of

familism ranged from 0 (strongly disagree) to 4 (strongly agree). Validity for the familism scale was originally tested by comparing Greek students' mean score of the familism score (46.95) who resided in a familistic community to American students' mean score (30.56) who lived in Michigan. The difference between the groups was significant (> .01). Several more comparisons were conducted between two culturally distinct groups with different samples and produced significant differences (Bardis, 1959a, 1959b). Reliability was established by a Spearman-Brown split-half reliability testing, where the Greek sample showed reliable coefficient of .77 and the American sample presented reliable coefficient of .84. A third day test-retest reliability with Greek sample was .904 (Bardis, 1959b).

Youn, Knight, Jeong, and Benton (1999) used the familism scale in their multi-ethnic caregiver research. The sample was composed of Korean, Korean American, and White caregivers. Cronbach's alpha for their sample was .83. As predicted, Korean caregivers group showed highest scores in the familism scale, whereas White group showed lowest familism scores. Korean American caregivers were in the middle.

Attitude toward Caregiving

Attitude toward caregiving is conceptually defined as caregivers' perceptions of their experience of caring for their relative. It was measured by Farren's Finding Meaning Through Caregiving Scale (FMTCS; Farren, 1999). The FMTCS measures finding meaning through caregiving from an existential point of view. The scale is composed of three

subscales, including Loss/Powerlessness, Provisional meaning, and Ultimate meaning. Loss/Powerlessness recognizes difficult aspect of caregiving. Provisional Meaning measures how a caregiver finds day-to-day meaning. Lastly, Ultimate Meaning tests philosophical/religious/spiritual acknowledgments related to the caregiving experience.

The FMTCS shows good reliability and validity, which are well described in Farren et al.'s (1999) study to test reliability and validity of the measurement. They tested this measurement with forty six home based dementia caregivers. A study with multi-racial 215 spousal caregivers was also included to confirm the fidelity of this measurement. Cronbach alpha internal consistency reliabilities of the FMTCS were .88 with forty six cases and .95 with 215 casees.

The measurement also showed good convergent and discriminant validity. According to Rubin and Babbie (2001), convergent validity can be found when the instrument corresponds to other measurements which measure the same construct. Whereas, discriminant validity is found when the result does not highly correspond to the measurement of an alternative construct like they match to different measurement of the same construct (Rubin, & Babbie, 2001).

Loss/Powerlessness Subscale showed positive correlations with caregiver stress measurements (frequency of behavior problem scale, CES-D, Global role strain, and marital tension), which were r=.38 to .70, confirming good convergent validity. Discriminant validity

was supported by inverse relationships between Provisional Meaning, Ultimate Meaning, and Total Meaning and each of these stress instruments (frequency of behavior problem scale, CES-D, Global role strain, and marital tension), which were r=-.28 to -.64 (Farren et al., 1999).

Convergent validity of Provisional Meaning was established by positive relationships with measurements of marital satisfaction, caregiver satisfaction, and personal gain, which were r=.24 to .64. Discriminant validity was supported by inverse relationships between Loss/Powerlessness and these caregiver measurements of satisfaction, caregiver satisfaction, and personal gain, which were r=-.38 to -.53. Moreover, there were insignificant or weak relationships between these measurements and Ultimate Meaning, which were r=.25 to .26 (Farren et al.,1999)

Lastly, Ultimate Meaning also presented good convergent and discriminant validity. The convergent validity of Ultimate Meaning was supported by positive relationships between Ultimate Meaning and measurements on religious participation, nonorganized religion, and satisfaction with organized religious support, which were r=.24 to .61. Discriminant validity was supported by inverse relationships between Loss/Powerlessness and these religiosity measurements, which were r=-.11 to -.22. There were also inverse relationships between Provisional Meaning and these religiosity instruments, which were r=.20 to .49, confirming good discriminant validity of Ultimate Meaning subscale (Farren et

al.,1999).

The response option of FMTCS ranged from 0 (strongly disagree) to 4 (strongly agree). The possible score ranges are from 0 to 172 and highest score reflect more positive attitude toward caregiving. Total summed score from three sub-scales was used to represent a caregiver's score on attitude toward caregiving.

Table 3.1: Summary: Definition of Variables

Variable	Definition
Independent variables	
Demographic factors	
Caregiver's Age	Continuous score indicating a year caregiver was born
Gender	1) Male 2)Female
Annual family income	1) Less than $5000 2) $5000-$9,999 3) $10,000-$14,999 4) $15,000-$19,999 5) $20,000-$29,999 6) $30,000-$39,999 7) $40,000-$49,999 8) $50,000-$59,999 9) $60,000-$69,999 10) $70,000 or more
Education	1) No Education 2) Elementary School 3) Middle School 4) High School 5) Some College/Associate degree 6) College Graduate 7) Doctoral Degree (PhD, MD, EdD., D.V.M., DDS., JD, etc.)
Relationship (spouse, child, relative, or others)	1) Spouse 2) Daughter 3) Daughter-in-law 4) Son 5) Other
Co-residency	1)Yes 2)No 3)Other
Stressor factors	
Amount of care a caregiver provides	Continuous score indicating an hour caregiver spend directly caring for or supervising the care receiver per day.
Duration of Caregiving	Continuous score indicating years a caregiver has taken care of the care receiver.

(Table continues)

Table 3.1: Summary: Definition of Variables (Continued)

Care receiver's problem behaviors	Continuous score indicating caregiver's score on the Revised Memory and Behavior Problems Checklist (Teri et al., 1992)
Social Support factors	
social support	Continuous score on items related to the level of social support and satisfaction with received social support.
Cultural factors	
Acculturation	Continuous score on items related to the level of dementia caregiver's acculturation into the U.S. norm.
Years in the U.S.	Continuous score indicating years in the U.S.
Filial piety	Continuous score indicating caregiver's score on filial piety
Familism	Continuous score indicating caregiver's score on the familism scale (Bardis, 1959)
Dependent variables	
Attitude toward caregiving	Continuous score indicating caregiver's score on FMTCS (Farren, et al., 1999).

Plan for Analysis

One-way analysis of variances (ANOVAs) and χ^2 tests were be used to examine the differences in demographic, stressor factor, social support factors, cultural factors, and the dependent variable, attitude toward caregiving, between spousal caregivers, children caregivers, and other family caregivers other than spouse and children. Interaction effect of social support and acculturation on Korean American dementia caregiver's attitude toward caregiving was tested. Hierarchical multiple regression was employed to analyze differential

effects of stressor factors, social support factors, and cultural factors on caregiver's positive attitude toward caregiving. To control for demographic factors, these variables was entered first as a block. Stress factor, amount of caregiving, duration of caregiving, and care receiver's problem behaviors were be included as a second block. Social support was entered as a third block. Lastly, the forth block contained cultural factors, including level of acculturation, filial piety, and familism. The order of entry of blocks was based on historical and theoretical considerations in the literatures on dementia caregiving and minority cultures (Chapell, & Reid, 2002; Knight, Silverman, McCallum, & Fox, 2000; Schulz, & Beach, 1999).

Outliers, missing variables, and assumption test

The data set was evaluated for missing data and outliers prior to the multivariate analysis and other tests. No extreme outliers existed. There were nine missing data throughout the 85 cases (2 cases in the daily caregiving amount, 1 case in the duration of caregiving, and 6 cases in the U.S. stay years). The comparisons between spouse caregivers and children along with the comparison between spouse and non-spouse caregivers by t-test were conducted with the cases with missing variables. The test on the interaction effect of social support and acculturation on dependent variable was conducted with the cases since they were not affected by the missing variables. The seven cases with missing variables were dropped and only those observations with complete data (Hair, 1998) were used in this

multivariate analysis. The underlying assumptions of multivariate model, which are normality of residuals, homoscedasticity, linearity, and independence of the error terms (Hair, 1998) were evaluated as well.

Normality. Multivariate regression assumes that the errors or residuals present normal distribution (Schwab, 2007). To test the normality, Shapiro-Wilk test of studentized residual was used. In this test, the null hypothesis is 'the distribution of errors is normally distributed.' The test yielded a statistical value of .978, which was more than the alpha level for diagnostic tests (p=.010). Since it was fail to reject the null, it was concluded that the distribution of the residual is normally distributed. The assumption of normality of errors was met.

Linearity. Multivariate regression assumes that the relationship between independent variables and dependent variable is linear (Schwab, 2007). Partial regression plots were utilized to test the linearity of the model. The curvilinear relationship between the quality of social support and the dependent variable was suspected visually in the partial regression plots. Therefore, the squared term of the quality of social support tested the culvilinearity between the two variables. The squared term was not significant in the model so the curvilinear relationship between the two variables was not included.

Homoscedasticity. The homogeneity of the error variance across independent variables is assumed in multiple regression (Schwab, 2007). The homoscedasticity was tested

with Breush-Pagan test where the null hypothesis was the variance of the residuals is same across the independent variables. For this analysis, the Breusch-Pagan test statistics was 31.983. The probability of the statistic was p=.004, which is smaller than the alpha level for the diagnostic test (p=.010). The null hypothesis was rejected and the assumption of homogeneity of error variance was violated. Since none of the transformation (i.e., logarithmic transformations, square root transformation, inverse transformation, and square transformation) produced homogeneity of the error variance, the original variables were used in the analysis with caution.

Independence of the error terms. In regression, it is assumed that the errors are independent and there is no serial correlation. The predicted value should not be predicted by other prediction (Schwab, 2007). The independent of the error terms was tested with Durbin-Watson statistic test for the existence of serial correlation among the residual. If the Durbin-Watson statistic falls between 1.50 to 2.50, the residuals are independent to each other. Since the analysis with this sample yield 1.397 which is not in the acceptable range, it was concluded that the residuals of this analysis were dependent to each other. Therefore, the original variables were used in the analysis with caution due to the violation of regression assumptions.

Table 3.2: Hierarchical Regression Models

Variable
Independent variables
Demographic factors
Caregiver's Age
Gender
Income
Education
Relationship (Spouses vs. non-spouses)
Co-residency
Stressor factors (step 1)
Care receiver's problem behavior
Amount of care a caregiver provides
Duration of caregiving
Social support factors (step 2)
Amount of social support
Quality of social support
Cultural factors (step 3)
Acculturation
Years in the U.S.
Filial piety
Familism
Dependent variable
Attitude toward caregiving

CHAPTER IV

RESULTS

In this chapter, the results of all analyses are presented. This chapter is composed of three parts: (1) descriptive analyses, (2) hypotheses testing, and (3) exploratory analysis. The significance level of .05 was established for all analyses. Due to the exploratory nature of this study, the significance level of .10 was also reported.

Descriptive Analyses

Demographics

The caregivers' mean age was 62.56 years (*SD*=13.22). Consistent with previous studies, the majority (77.6%) of the caregivers were female. Annual income of almost half of the participants (48.2%) was below $30,000, which can be expected considering immigrant seniors low socio-economic status in the U.S. In terms of education, 29.4% reported having a high school degree and 49.5% reported having a more than a high school degree. Majority of the caregivers were spouse caregivers (38.8%), followed by daughters (25.9%) and daughters-in-law (10.6%). 63.5% of the caregivers were living with a family member with dementia. The mean caregiving hours the caregivers provide was 10.66 hours per day. The caregivers have been providing caregiving for 3.73 years in average. All of the caregivers were immigrants and their average years in the U.S. was 17.42 years.

The age of the care receivers ranged from 60 to 100 years with a mean of 80.85 years

(SD=8.86). The majority of the care receivers were males (61.2%).

Table 4.1: Demographic Statistics of Study Participants (N=85)

Demographic Characteristics	
Caregiver's Age	
30-39	4.7 %
40-49	11.8 %
50-59	28.2 %
60-69	21.2 %
70-79	23. 5%
80-91	1.6 %
Caregiver's Gender	
Male	22.4 %
Female	77.6 %
Care receiver's Age	
60-69	11.8 %
70-79	28.2 %
80-89	43.5 %
90-99	15.3 %
100-109	1.2 %
Care receiver's Gender	
Male	61.2 %
Female	37.6 %
Income	
Less than $5,000	9.4 %
$5,000-$9,999	8.2 %
$10,000-$14,999	21.2%
$15,000-$19,999	18.8 %
$20,000-$29,999	11.8 %
$30,000-$39,000	10.6 %
$40,000-$49,000	4.7 %
$50,000-$59,999	2.4 %
$60,000-$69,000	3.5 %
$70,000 or more	9.4 %
Education	
No Education	3.5 %
Elementary School	9.4 %
Middle School	8.2 %
High School	29.4 %
Some college/Associate Degree	21.2 %
College Graduate	25.9 %
Doctoral Degree	2.4%

(Table continues)

Table 4.1: Demographic Statistics of Study Participants (N=85) (Continued)

Demographic Characteristics	
Relationship	
Spouse	38.8 %
Daughter	25.9 %
Daughter-in-law	10.6 %
Son	9.4 %
Others	15.3 %
Co-residency with care receiver	
Yes	63.5 %
No	36.5 %
Amount of care per day (in hours)	M=10.66 (SD=8.09)[range=0-24]
Duration of caregiving (in months)	M=44.74 (SD=49.52)[range=1-270]
Yeas in the U.S. (in years)	M=17.42 (SD=9.56)[range=1-43]

Bivariate correlations among study variables are presented in Table 4.2 to provide broad understanding of the relations among the study variables. The relations concerning dependent variables were interpreted below despite of numerous significant relations. Dementia caregiver's attitude toward caregiving was significantly associated with the quality of social support they receive ($r(83)=.406$, $p<.01$), the level of acculturation ($r(83)=.304$, $p<.01$), income ($r(83)=.302$, $p<.01$), familim ($r(83)=.297$, $p<.01$), amount of social support ($r(83)=.289$, $p<.01$), relation to care receiver ($r(83)=-.287$, $p<.01$), and education ($r(83)=.256$, $p<.05$).

Table 4.2: Intercorrelations among Study Variables

variables	Age	Gender	Income	Educa-tion	Relati-on	Coresi-dency	Prob-lems	Care Amount	Care Duration	Support Amount	Support Quality	U. S. years	Accultu -ration	Famili-sm	Filial piety	Attitude
Age	–															
Gender	.005	–														
Income	-.440**	.173	–													
Education	-.464**	.216*	.328**	–												
Relations	.667**	-.022	-.380**	-.404**	–											
Coresidency	.347**	-.063	-.285**	-.339**	.553**	–										
Problems	-.015	-.011	.017	.028	.031	.114	–									
Care amount	.245*	-.128	.299**	-.295**	.491**	.665**	.086	–								
Care duration	.112	-.028	.047	-.014	.142	.117	-.039	.114	–							
Support amount	-.176	.005	.293**	.210	-.225*	-.118	-.003	.097	.039	–						
Support quality	-.034	.062	.191	.218*	-.175	-.188	-.055	-.333**	.007	.449**	–					
U.S years	.101	.128	.249*	.104	-.147	.058	-.173	.015	.219	.244*	.238*	–				
Acculturation	-.410**	.076	.381**	.420**	-.457**	-.207	-.079	-.237*	.062	.423**	.259*	.350**	–			
Familism	-.010	.163	.137	.046	-.148	-.138	.036	-.156	-.125	.098	.243*	.073	.061	–		
Filial piety	-.114	.154	.104	.167	-.122	-.033	-.115	-.196	-.041	-.007	.146	.119	.047	.390**	–	
Attitude	-.198	.099	.302**	.256*	-.287**	-.228	-.166	-.157	-.027	.289**	.406**	.090	.304**	.297**	.238*	–

Note: *p<.05, **p<.01, ***p<.001.

For purpose of the correlation test, the variable 'relations' was dichotomized into spouse caregivers and non-spouse caregivers.

Comparisons among spouse caregivers, children caregivers, and other family caregivers on the study variables

For descriptive analysis, one-way analysis of variances (ANOVAs) and χ^2 tests were conducted to compare differences among spouse caregivers, children caregivers, and family caregivers other than spouse and children on the study variables. Table 4.3 (p.102) provides the findings from the ANOVA (continuous variables) and χ^2 tests (categorical variables). Bonferroni's post-hoc tests were performed to compare the statistical differences between the three caregiver groups. Among the samples, 38.8% (*N*=33) was spouse caregivers and 46% (*N*=39) was children caregivers (daughter, son, and daughter-in-law). Fifteen percent (*N*=13) of the sample were close family caregivers other than spouse and children.

There were significant differences among the caregiver groups with respect to age ($F(2,82)=33.36$, $p<.001$), income ($F(2,82)=7.66$, $p<.01$), education ($F(2,82)=8.06$, $p<.01$), co-residency with a care receiver ($F(2,82)=21.01$, $p<.001$), care amount per day ($F(2,80)=12.74$, $p<.001$), acculturation ($F(2,82)=11.51$, $p<.001$), filial piety ($F(2,82)=4.74$, $p<.05$), and attitude toward caregiving ($F(2,82)=3.69$, $p<.05$). On average, spouse caregivers were the oldest (*M*=75.58) and reported the highest co-residency with care receivers (97%) as expected. They spent the largest amount of time in caregiving per day (*M*=15.52) compared to children and other family caregivers. The children caregivers reported being the youngest (*M*=55) and the highest income (*M*=5.64) and highest level of acculturation into the U.S. (*M*=8.49). They showed highest filial piety (*M*=6.51) among the three caregiver groups. The other family caregivers group reported highest level of education (*M*=5.00).

Attitude toward dementia caregiving significantly varied by caregivers'

relationship to care receipients. Contrary to the presumption of spouse caregivers' highest positive attitude toward caregiving, family caregivers other than spouse and children showed the highest positive attitude toward caregiving (*M*=104.32, *SD*=12.10), whereas the spouse caregivers reported lowest positive attitude toward caregiving (*M*=93.76, *SD*=18.20). Post-hoc analysis using bonferroni's post-hoc criterion for significance indicated the attitude toward caregiving caregiving was significantly lower in spouse caregivers group (*M*=93.76) than children caregivers group (*M*=103.59).

Table 4.3: Comparison among spouse caregivers, children caregivers, and other familycaregivers on study variables

Variable	Spouse caregivers (*N*=33)	Children caregivers (*N*=39)	Other family caregivers (*N*=13)	Total Sample (*N*=85)
Dependent variable				
Attitude toward caregiving*	93.76 (18.20)	103.59 (16.36)	104.32 (12.10)	99.88 (17.10)
Demographic Factors				
Age (years)***	75.58 (8.63)	55 (9.17)	57.31 (14.50)	62.56 (13.23)
Female	70%	79%	69%	78%
Income**	3.42 (1.52)	5.64 (2.77)	4.77 (2.98)	4.65 (2.58)
Education**	3.70 (1.55)	4.85 (1.09)	5.00 (1.42)	4.42 (1.44)
Co-residency w/care receiver***	97%	49%	23%	64%
Stressor Factors				
Care receiver's problem behaviors	11.68 (3.91)	11.48 (4.45)	11.13 (5.59)	11.51 (4.39)
Care amount per day (hours)***	15.52 (5.60)	7.62 (8.17)	6.92 (7.40)	10.66 (8.09)
Duration of caregiving (months)	53.42 (46.09)	34.46 (40.73)	54.25 (76.75)	44.74 (49.52)
Social Support Factors				
Amount of social support	18.19 (7.05)	21.08 (7.45)	23 (6.78)	20.25 (7.33)
Quality of social support	4.42 (2.08)	5.21 (2.40)	5.23 (1.83)	4.91 (2.21)
Cultural Factors				
Acculturation***	6.12 (2.06)	8.49 (1.99)	7.77 (2.52)	7.46 (2.35)
Years in the U.S.	15.63 (7.47)	18.94 (10.18)	17.31 (12.01)	17.42 (9.56)
Filial piety*	5.91 (1.23)	6.51 (1.05)	5.39 (1.71)	6.11 (1.29)
Familism	42.63 (8.85)	46.45 (8.58)	42.23 (10.92)	44.32 (9.17)

Notes: Variables are means (*SD*) or percentages. χ^2 test was used for categorical variables and ANOVA was used for continuous variables with Bonferroni post-hoc test.
*p<.05, **p<.01, *** p<.001.

Hypotheses Testing

Research Question 1

Do Korean American dementia spouse caregivers have a more positive attitude toward caregiving than do child caregivers?

Hypothesis 1.

Korean American spouse caregivers will report significantly higher scores on the measure of attitude of caregiving than Korean American child caregivers.

Hypothesis 1 was not supported. The comparison testing using an independent T-test (Table 4.4) between spouse caregivers and child caregivers on their attitude toward caregiving resulted in a statistically significant difference, $t(70)=-2.412$, $p < .05$. Contrary to the hypothesis 1, findings indicated that child caregivers showed more positive attitude toward caregiving ($M=103.59$, $SD=16.36$) than spouse caregivers ($M=93.76$, $SD=18.20$).

Table 4.4: Comparison of spouse caregivers and child caregivers on their attitude toward caregiving

	Spouse caregivers (N=33)		Child caregivers (N=39)		t-statistics
Variable	*Mean*	*SD*	*Mean*	*SD*	
Attitude	93.76	18.20	103.59	16.36	-2.412*

Notes: *$p<.05$, **$p<.01$, *** $p<.001$.

Research Question 2
Is there an interaction effect between the level of acculturation and social support on Korean American dementia caregivers' attitude toward caregiving?

Hypothesis 2.

Effect of social support on Korean American caregiver's positive attitude toward caregiving will be greater in more acculturated group than in less acculturated group.

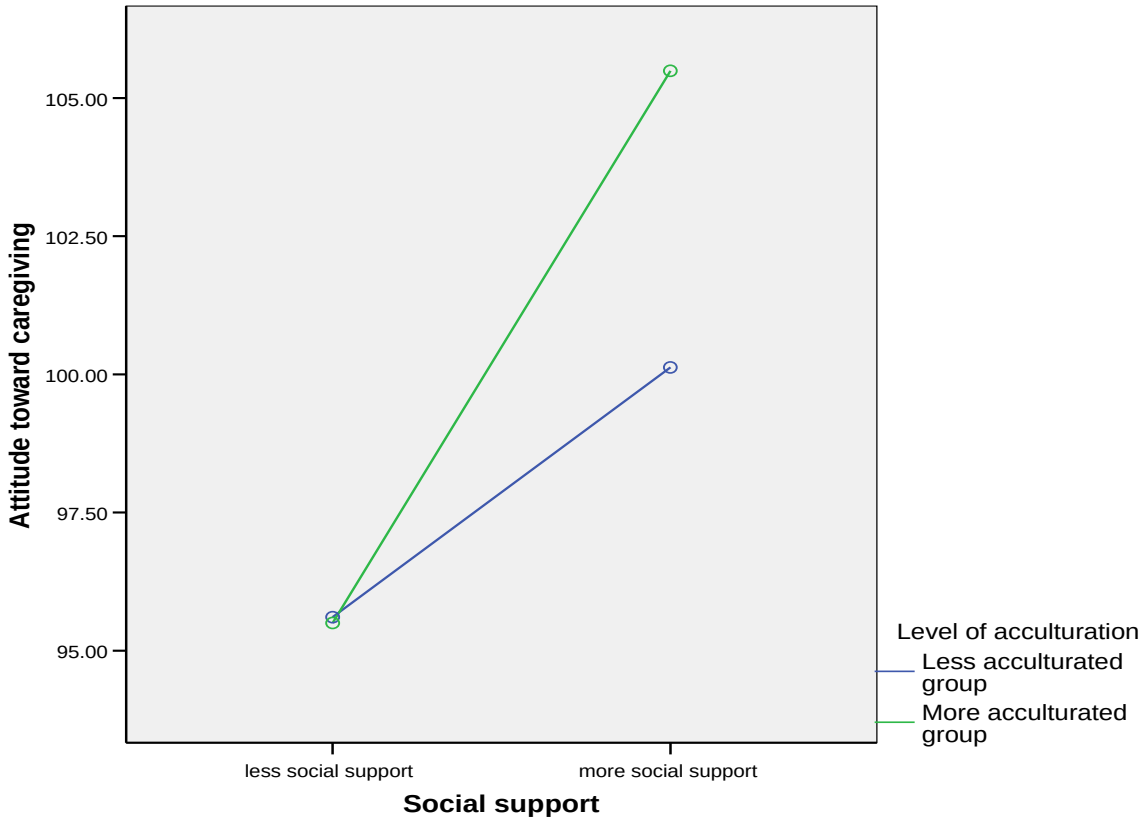
Hypothesis 2 was not supported. The result of regression analysis (Table 4.5, p.105) shows that the effect of social support on the caregiver's attitude toward caregiving does not vary by their level of acculturation, $t(81)=-.222$, $p=.825$. An additional analysis of the interaction effect on seperature groups (spouse vs. non-spouse) does not bring any more significant result. To test the interaction effect, the social support score was summation of the amount of social support and the quality of social support. Both of the variables are metric variables. The interaction term is the multiplication of social support by the level of acculturation. Further analysis was conducted to investigate the negative coefficient of the interaction term, which is not logical considering the positive relations of acculturation and social support on the dependent variable. The social support and acculturation variables were divided into two groups using their means and the interaction effect of the two variables on attitude toward caregiving was tested. The following graph (Figure 4.1, p.105) shows that social support has more positive impact on attitude toward caregiving for the Korean American caregivers who are more acculturated caregivers than less acculturated caregivers even though the interaction effect is not statistically significant.

Table 4.5: Caregiver' attitude toward caregiving as a function of interaction effect of social support and acculturation

Variables	Beta
Social support	.347
Acculturation	.269
Social support × level of acculturation	-.134
R-Squared	.153
Adjusted R-Squared	.122

Notes: Cell entries represent standardized OLS regression coefficients.
*p<.05, **p<.01, ***p<.001.

Figure 4.1: Interaction effect of social support and acculturation on attitude toward caregiv



Research Question 3

To what extent is a Korean dementia caregiver's attitude toward caregiving influenced by stressor factors, social support factors, and cultural factors, controlling for demographic factors?

Research question 3 was answered by 3 hypotheses using hierarchical multiple regression analyses. In this analysis, 8 cases with missing data were removed and only those cases with complete data were used in this multivariate analysis. There was no pattern found in the description of missing data (2 cases in daily caregiving amount, 1 case in duration of caregiving, and 6 cases in years in the U.S.). Hierarchical multiple regression requires a minimum ratio (5:1) of valid cases to independent variables (15 variables in this analysis) (Schwab, 2007). Therefore, an N equal to 77 meets the minimum requirement.

Results of the regression analysis are shown in Table 4.6 (p.107). With all predictors in the equation, the model accounted for 24% of variances in Korean American dementia caregivers' the attitude toward caregiving.

Demographic variables were included in the model 1 as control variables. Caregiver's age, gender, income, education, relation (spouse caregivers vs. non-spouse caregivers), and co-residency (co-reside vs. living a part). Demographic factors explained 6% of the variances in Korean American dementia caregiver's attitude toward caregiving.

Table 4.6: Regression: Predictors of Korean American dementia caregivers' attitude toward caregiving (N=77)

	Model 1 Beta	Model 2 Beta	Model 3 Beta	Model 4 Beta
Intercept	82.415	84.473	77.888	42.794
Demographic Factors				
Age	.106	.136	.046	.159
Gender	.028	.038	.060	.047
Income	.246*	.269*	.190	.203
Education	.084	.117	.045	.071
Relationship (spouse vs. nonspouse)	-.168	-.208	-.136	-.197
Co-residency with care receiver	-.056	-.114	-.183	-.192
Stressor Factors				
Care-receiver's problem behavior		-.182	-.181*	-.231**
Amount of care a caregiver (hours)		.160	.279*	.361**
Duration of caregiving (months)		-.034	-.036	.021
Social Support Factors				
Amount of social support			.084	.115
Quality of social support			.360***	.335***
Cultural Factors				
Years in the U.S.				-.238*
Acculturation				.119
Filial Piety				.158
Familism				.145
F change	1.828	1.126	6.320***	2.007
R-Squared change	.135	.042	.134	.080
R-Squared	.135	.177	.311	.391
Adjusted R-Squared	.061	.066	.194	.241

Notes: Cell entries represent standardized OLS regression coefficients.
*p<.10, **p<.05, ***p<.01.

Hypothesis 3. Stressor factors

Korean American dementia caregivers will report significantly higher scores on attitude toward caregiving when they have less stressor factors, controlling for demographic factors.

Hypothesis 3 was not supported. In model 2, stress factors, which include care receivers' problem behaviors, amount of caregiving per day, and the duration of the caregiving in years, were tested. The addition of the stress factors reduced the errors in predicting caregivers' attitude toward caregiving by 4%. Counter to the hypothesis, the addition of stressor factors did not contribute to the overall relationship with the dependent variable, the caregivers' attitude toward caregiving significantly, $F(3, 67)=1.126$, $p=.345$. The research hypothesis that the stressor factors, which included care receiver's problem behaviors, amount of care, and duration of care, reduced the error in predicting the caregivers' attitude toward caregiving was not supported.

Hypothesis 4. Social support factors

Korean American dementia caregivers will report significantly higher scores on attitude toward caregiving when they have greater social support factors, controlling for demographic factors and stressor factors.

The hypothesis was supported. In model 3, social support factors, comprised of amount of social support and quality of social support, were tested. As expected, the hypothesis was supported where the social support factors contributed to the overall relationship with the Korean American dementia caregivers' attitude toward caregiving, $F(2, 65)=6.320$, $p<.05$. The research hypothesis that the social support factors, which included amount of social support, and quality of social support, reduce the error in predicting the caregivers' attitude toward caregiving was supported. The addition of the social support factors reduced the errors in predicting caregivers' attitude toward

caregiving by 13%.

Hypothesis 5. Cultural factors

There will be a significant relationship between cultural factors of Korean American dementia caregivers and an attitude toward caregiving, controlling for demographic factors, stressor factors, and social support factors.

The hypothesis was not supported. In a model 4, cultural factors, which is consisted of the years in the U.S., acculturation, filial piety, and familism, were tested. The addition of the cultural factors reduced the errors in predicting caregivers' attitude toward caregiving by 8%. Contrary to the hypothesis, the addition of cultural factors did not contribute to the overall relationship with the dependent variable, the caregivers' attitude toward caregiving significantly, $F(4, 61)=2.007$, $p=.105$. The research hypothesis that the cultural factors, which included years in the U.S., acculturation, filial piety, and familism reduce the error in predicting the caregivers' attitude toward caregiving was not supported.

Significant determinants of Korean American dementia caregivers' attitude toward Caregiving

As seen in Table 4.6 (p.107) in column for model 4 , among the various variables, the amount of caregiving was the most important factor determining the Korean American dementia caregiver's attitude toward caregiving (beta= .361, $t(61)=2.425$, $p< .05$), followed by quality of social support (beta=.335, $t(61)= 2.737$, $p< .01$) and care receiver's problem behaviors (beta=-.231, $t(61)= -2.175$, $p< .05$). Among the social support factors, quality of social support appeared as a significant predictor of the dependent variable. Higher quality of social support predicted the Korean American dementia caregivers' positive attitude toward caregiving. Among the stressor factors, care receiver's problem

behaviors and amount of daily care contributed significantly to the prediction of Korean American dementia caregivers' attitude toward caregiving. In other words, when care receivers had fewer problem behaviors, caregivers had more positive attitude toward caregiving.

Analysis of interaction effect between amount of care and culture

Unexpectedly, the amount of caregiving was the most important factor determining the Korean American dementia caregiver's attitude toward caregiving (b=.361, *p*=.034). As seen in Table 4.2, in the bivaiate correlation test, amount of care had negative correlation with caregiver's attitude toward caregiving (r=-.157, p=.156) where the caregivers who provide more care present a more negative attitude toward caregiving. However, in the final model with cultural factors, the result shows an inverse result where the caregivers with a higher amount of care show positive attitude toward caregiving. Therefore, some interaction effects among the amount of care and cultural factors were suspected and additional analyses were conducted to explain the complex result.

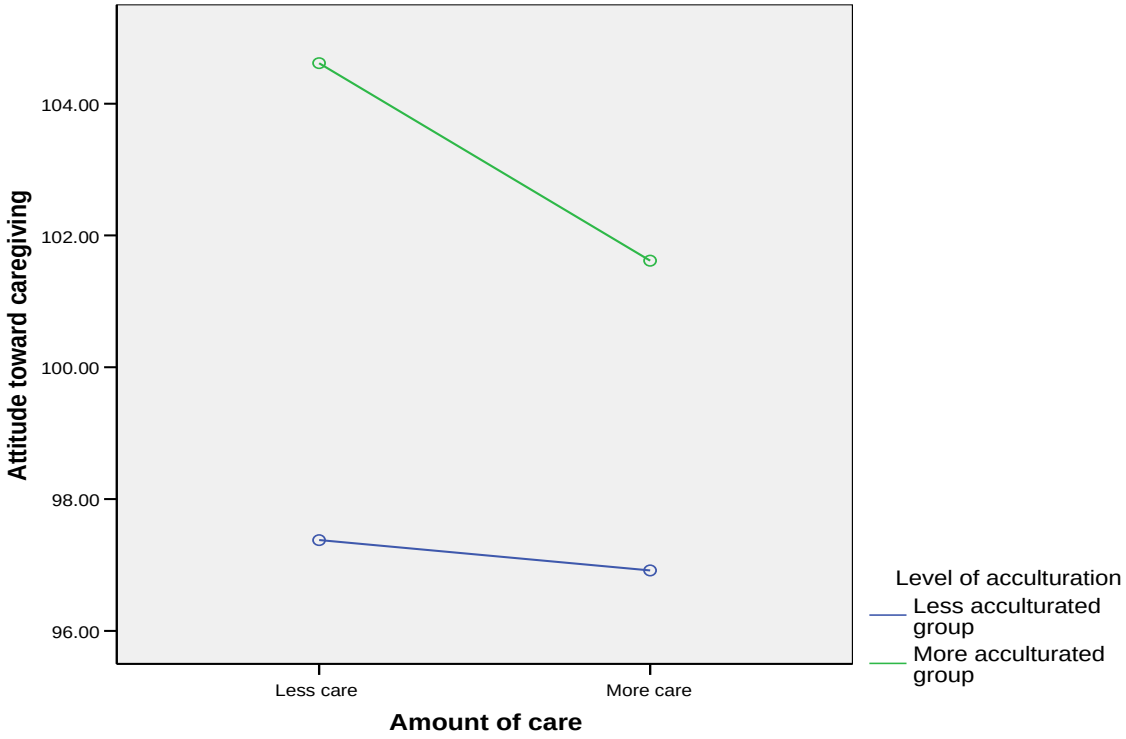
The Table 4.7 (p.111) shows there is no interaction effect between amount of care and the level of acculturation (*t*(79)=.886, *p*=.378). The effect of amount of care on the caregiver's attitude toward caregiving does not statistically differ according to their level of acculturation. Amount of care and acculturation are metric variables. The interaction term is the multiplication of amount of care by the level of acculturation. The following graph (Figure 4.2) shows amount of care has more negative impact on attitude toward caregiving for the Korean American dementia caregivers who are more acculturated in the U.S. culture than the ones who are less acculturated in to the U.S. even though the interaction effect is not statistically significant.

Table 4.7: Caregiver attitude toward caregiving as a function of interaction effect of amount of care and acculturation

Variables	Beta
Amount of care	-.450
Acculturation	.133
Amount of care × level of acculturation	.369
R-Squared	.331
Adjusted R-Sqaured	.076

Notes: Cell entries represent standardized OLS regression coefficients.
*p<.10, **p<.05, ***p<.01.

Figure 4.2: Interaction effect of amount of care and acculturation on attitude toward caregiving



The Table 4.8 (p.112) shows there is no interaction effect between amount of care and the familism (t(79)=.380, p=.705). The effect of amount of care on the caregiver's attitude toward caregiving does not statistically differ according to their familism. Amount of care and familism are metric variables. The interaction term is the

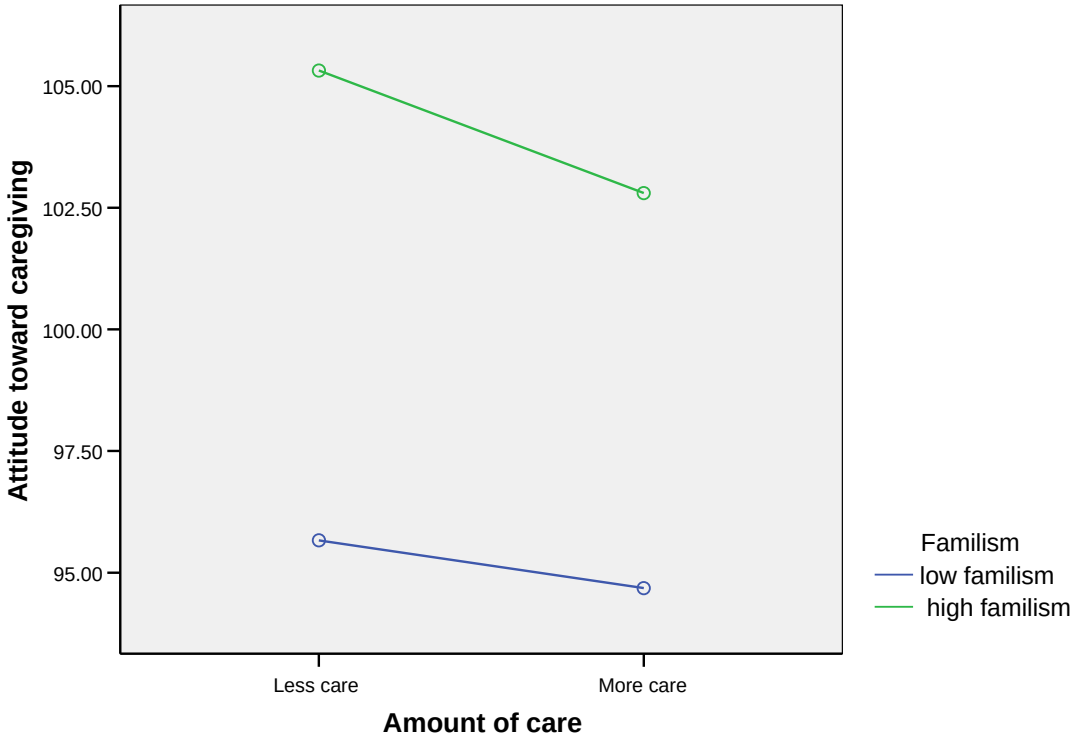
multiplication of amount of care by the level of familism. The following graph (Figure 4.3) shows the impacts of the amount of care on attitude toward caregiving are almost similar in both high familism and low familism groups.

Table 4.8: Caregiver attitude toward caregiving as a function of interaction effect of amount of care and familism

Variables	Beta
Amount of care	-.329
Familism	.220
Amount of care × familism	.217
R-Squared	.100
Adjusted R-Sqaured	.066

Notes: Cell entries represent standardized OLS regression coefficients.
*p<.10, **p<.05, ***p<.01.

Figure 4.3: Interaction effect of amount of care and familism on attitude toward caregiving



The hypotheses testing found that child caregivers showed a more positive attitude toward caregiving then spouse caregivers. The effect of social support on the caregiver's attitude toward caregiving did not vary by their level of acculturation. Among the three hypotheses with hierarchical multiple regression, only 1-- on the positive role of social support on the attitude toward caregiving-- was supported. Among the predictors, amount of caregiving per day was the most significant variable, followed by the quality of social support, and care receivers' problem behaviors.

Exploratory Analysis

Even though the research hypotheses were created with support from literature reviews, only 1 hypothesis of 5 was supported. Further analysis was conducted to explore what were preventing significant relationships among the study variables.

Comparison of beta coefficients between spouse caregivers and non-spouse caregivers

Exploratory analysis using separate hierarchical regression was conducted to compare the beta coefficients between spouse caregivers and non-spouse caregivers. As seen in Table 4.9 (p.117), the separate analyses yielded different patterns of predictors of dementia caregivers' attitude toward caregiving. The R^2 from spouse caregivers and non-spouse caregivers were 85% and 33%, respectively. In the analysis with spouse caregivers, 3 predictors had significant relationships with the dependent variables. In the analysis with non-spouse caregivers, only 1 variable had a significant relationship with the dependent variable.

Spouse caregivers sample only

For the spouse caregivers, the demographic factors accounted for 50% of the variance in attitude toward caregiving. Among the demographic factors, income (beta=.772, $t(30)= 5.855$, $p<.01$) and education (beta=.363, $t(30)= 2.368$, $p<.05$) significantly contributed to the prediction of the spouse caregivers' attitude toward caregiving. The addition of stress factors into the model did not produce a significant contribution in prediction of variance. None of the stressor factors significantly predicted the spouse caregivers' attitude toward caregiving.

The addition of social support factor significantly contributed to the explanation of the spouse caregivers' attitude toward caregiving. After controlling for demographic

factors and stress factors, social supported factors made a significant contribution to the prediction of the spouse caregivers' attitude, accounting for 22% of the variance. Quality of social support (beta=.686, $t(30)= 4.196$, $p<.01$) was an important predictor of the spouse caregivers' attitude toward caregiving. Lastly, the cultural factors failed to explain additional significant variance. However, considering the low sample size ($N=30$), predictors which were close to significance, years in the U.S. (beta=-.278, $t(30)=-1.958$, $p=.069$) and familism (beta= .225, $t(30)=1.842$, $p=.085$), can be regarded as potential predictors of the Korean American spouse dementia caregivers' attitude toward caregiving. With all predictors in the equation, the model accounted for 85% of variances in Korean American spouse dementia caregivers' the attitude toward caregiving.

Among the variables, income was the most important factor determining the Korean American spouse dementia caregiver's attitude toward caregiving (beta=772, $t(15)=5.855$, $p< .01$), followed by quality of social support (beta=.686, $t(15)= 4.196$, $p< .01$) and education (beta=.363, $t(15)=2.368$, $p<.05$). Among the demographic factors, income and education contributed significantly to the prediction of Korean American spouse dementia caregivers' attitude toward caregiving. Higher income and education predicted the caregivers' positive attitude toward caregiving. Among social support factors, only quality of social support was a gnificant predictor of the dependent variable. Higher quality of social support predicted the Korean American spouse dementia caregivers' positive attitude toward caregiving.

Non-spouse caregivers sample only

The hierarical multiple regression analysis on the non-spouse sample presented different results. For the spouse caregivers, the demographic factors accounted for only 5% of the variance in attitude toward caregiving. None of the variables among demographic factors significantly contributed to the prediction of the spouse caregivers' attitude toward caregiving. The addition of stress factors into the model did not produce a significant contribution in prediction of variance, either. However, among the stressor factors, care receivers' problem behaviors (beta= -.332, $t(46)$= -2.045, $p<.05$) significantly contributed to the prediction of the spouse caregivers' attitude toward caregiving. In other words, the care receivers' less problem behaviors predicted the non-spouse caregivers' positive attitude toward caregiving. The addition of social support factor and cultural factors failed to explain additional significant variance. None of variables among social support factors and cultural factors significantly reduced the error in predicting non-spouse Korean American dementia caregivers' attitude toward caregiving.

With all predictors in the equation, the model accounted for only 33% of variances in Korean American non-spouse dementia caregivers' attitude toward caregiving. Only one variable, care receivers' problem behaviors was a significant predictor of the dependent variable. In sum, the R^2 from two caregiver groups are different (85% vs. 33%). The comparison analysis of beta coefficients between immigrant spouse caregivers and immigrant non-spouse caregivers shows the discrepancy of predictors of attitude toward caregiving experiences between the two groups. The result implies that the model tested in this study can not be applied to general caregiving populations. The model does not

explain the immigrant non-spouse caregivers' attitude toward caregiving. In other words, the model should be used in immigrant spouse caregiver groups.

Table 4.9: Comparison of beta coefficients between spouse caregivers and non-spouse caregivers

	Spouse Caregivers Sample (N=30)	Non-Spouse Caregivers Sample (N=46)	Combined Samples (*N*=77)
Intercept	-19.397	44.651	49.223
Demographic Factors			
Age	.231	.254	.046
Gender	-.192	.030	.036
Income	.772***	.060	.186
Education	.363**	.153	.060
Co-residency with care receiver	.043	-.153	-.242*
Stressor Factors			
Care-receiver's problem behavior	-.246*	-.332**	-.218**
Amount of care a caregiver (hours)	.208	.296	.326**
Duration of caregiving (months)	.111	.009	.006
Social Support Factors			
Amount of social support	.080	.170	.115
Quality of social support	.686***	.194	.337***
Cultural Factors			
Years in the U.S.	-.278*	-.285	-.188*
Acculturation	-.140	-.021	.136
Filial Piety	-.030	.291	.144
Familism	.225*	.129	.162
R-Squared	.850	.325	.391
Adjusted R-Squared	.711	.029	.241

Notes: Cell entries represent standardized OLS regression coefficients.
*p<.10, **p<.05, ***p<.01.

Summary

In sum, the comparison between spouse caregivers and child caregivers on their attitude toward caregiving disclosed that child caregivers have more positive attitude toward caregiving than the spouse caregivers, which was contrary to the assumption. The hypothesis on the interaction effect between social support and acculturation was not supported. In the analyses with hierarchical multiple regression, only one hypothesis of three was significant. Korean American dementia caregivers reported significantly positive attitude toward caregiving when they have greater social support, controlling for demographic and stressor factors. In the final regression model (Table 4.6, p.107), three variables (care receiver's problem behavior, amount of care the caregivers provide, and quality of social support) had significant relationship with the dependent variable. Among them, the amount of caregiving was the most important factor determining the Korean American dementia caregiver's attitude toward caregiving (beta=.361, *p*=.034), followed by quality of social support (beta=.335, *p*=.008) and care receiver's problem behaviors (beta=-.231, *p*=034). The cultural factors, which were assumed to be most important in Korean American dementia caregiver's attitude toward caregiving were not important in this study.

Exploratory additional comparison of beta coefficients between spouse caregivers and non-spouse caregivers revealed the R^2 from two caregiver groups are different, 85% and 33%, respectively. Discrepancy of predictors of attitude toward caregiving exists and the model can not be applied to general caregiving populations. Considering the high R^2 from the spouse caregivers group, it is assumed that more hypotheses could be supported in a test with more spouse caregiver samples. It is suggested the model should be used in immigrant spouse caregiver groups only.

CHAPTER V

DISCUSSION AND IMPLICATIONS

This chapter presents the interpretations of the study results and discussions, followed by implications for social work practice and policy. It addresses implications for future research. In addition, the limitations of this study are discussed. Finally, conclusions are provided.

The purpose of this study was to explore how Korean American caregivers view dementia caregiving and reveal factors that contribute to their attitude toward caregiving. Demographic characteristics, stressor factors, social support factors, and cultural factors were examined in the model. The study compared a group of spouse caregivers with a group of children providing care in order to investigate the differences in their attitudes toward caregiving. In addition, the interaction effect between social support and acculturation in dementia caregiver's attitude toward caregiving was examined.

There were five hypotheses investigated in this study. Of the five, only one-- on the positive role of social support on the attitude toward caregiving-- was supported. Children caregivers showed more positive attitude toward caregiving then a spouse caregivers. Among the predictors of Korean American dementia caregivers' attitude toward caregiving, amount of caregiving per day was the most significant variable, followed by the quality of social support. Higher levels of daily caregiving and higher quality of social support were positively related to positive attitudes toward caregiving. Comparison of beta coefficients from the spouse caregiver group and non-spouse caregiver group revealed the discrepancy of predictors of Korean American caregivers' attitude toward caregiving between the two caregiving groups.

Discussion of Research Question 1

Do Korean American dementia spouse caregivers have a more positive attitude toward caregiving than do child caregivers?

It was hypothesized that Korean American spousal caregivers would report significantly higher scores on the measure of attitudes toward caregiving than would Korean American child caregivers. This hypothesis was not supported. The results revealed that child caregivers showed significantly more positive attitudes toward caregiving, the opposite direction of the hypothesis. The hypothesis was conceptualized on Lawton et al.(1991)'s idea on of family caregiving in human development. They described that a caring husband or wife is part of an experience of marital commitment and "normal" human development. For children, however, caring for a parent is an extra activity in addition to current roles. They are therefore more burdened, and their psychological well-being is challenged by the addition of a caregiving workload.

The unexpected result could be explained by spousal caregivers' economic hardship. The Korean American spouse caregivers had significantly lower incomes ($t(70)=-4.294$, $p<.01$) when compared to the children caregivers. Income showed significantly positive correlations ($r=.302$, $p<.01$) with the dementia caregivers' attitude, which helps explain the dynamics among relationship, income, and attitude toward caregiving. Some researchers argue that spousal caregivers are more vulnerable to psychological and physical morbidity in some aspects. In Pinquart and Sorensen' (2003) review, spousal caregivers showed higher levels of burden and depression, and lower subjective well-being than other caregiving groups. Hooker et al. (1998) mentioned that spousal caregivers are already fragile populations due to their own health issues and lack of social support. Low income is one of the major burdens in caregiver's family.

Research shows that lower household income is highly related to caregivers' depression (Convinsky et al.,2003) and caregivers with higher income appraised the caregiving situation as more satisfactory and beneficial (Lee, Brennan, & Daly, 2001). Considering their own aging issues, the Korean American spouse caregivers who are under pressure of economic hardship can show negative attitude toward caregiving despite the gains or benefits they receive from the caregiving.

The different standard of adequate caregiving can be one of the explanations of spouse caregivers' negative attitude toward caregiving. Even though it was not comparison study between spouse caregivers and children caregivers, Jolicoeur and Madden (2002) showed evaluations of caregiving experiences can be different by caregivers' definition of "adequate caregiving". Thirty-nine Mexican American caregivers, comprising both high-acculturation and low-acculturated groups, disclosed that the definition and expectation of being a good daughter were different in the two groups. Researchers using qualitative analysis found that one quarter to one third of the less acculturated caregivers could not recognize the phrase 'satisfied with…'. For them, providing caregiving to parents is simply part of being a child and not something that necessarily generates personal satisfaction. In a similar vein, the Korean American caregivers in this study can see the caregiving as a part of being a spouse. Therefore, there can be a certain standard to be a good spouse who takes care of their spouse appropriately. Spouse caregivers who do not meet the standard feel pressured and present negative attitudes toward caregiving compared to the child caregivers with possibly lower standards of family caregiving.

Discussion of Research Question 2

Is there an interaction effect between the level of acculturation and social support on Korean American dementia caregivers' attitude toward caregiving?

It was hypothesized that effect of social support on Korean American caregivers' attitude toward caregiving will be greater in more acculturated caregivers than in less acculturated caregivers. The hypothesized interaction effect between social support and acculturation was not supported in this sample. This is inconsistent with current literature on the interaction effect between social support and acculturation on immigrants' psychological well-being (Lee, Koeske, & Sales, 2004). In Lee, Koeske, and Sales' study (2004), social support significantly moderated the effect of acculturative stress on mental health in Korean Americans groups who are more acculturated into the American culture and interpersonal relations compared to those who are less acculturated.

These results may be explained by the unique experience of acculturation of Korean Americans. Most of the individuals in this study reside in Los Angeles, Chicago, or Houston area where Korean immigrants create and live in their own cultural enclave. The immigrants group resides in the homogeneous environment where the level of acculturation does not vary across the population. Considering their protected and limited environment, the Korean immigrants would receive a certain level of social support regardless of their level of acculturation. Therefore, this population would not be an appropriate sample to test the interaction effect of social support and acculturation on psychological well-being.

As Harwood et al. (2000) argue, acculturation is a complicated topic in the research on homogeneous immigrant populations. In their study of Cuban American dementia caregivers, the length of residence in the U.S., the measure of level of

acculturation in the study, was not related to caregivers' appraisal of caregiving. Harwood et al., explained that Cuban Americans live in homogeneous environment where they have generated their own cultural community and replicated their cultural origins and behaviors. They create and benefit from their own social support system. The researchers, therefore, conclude that the level of acculturation would be more important factor in dementia caregiving research with newly immigrated Hispanic caregiving population.

Discussion of Research Question 3

To what extent is a Korean dementia caregiver's positive attitude toward caregiving influenced by stressor factors, social support, and cultural factors, controlling for demographic factors?

In order to answer the question, three hypotheses, containing nine different variables, were analyzed with the dependent variable, attitude toward caregiving. The nine variables were related to stressor factors, social support factors, and cultural factors. In the final model containing all variables, amount of daily care, quality of social support, and care receivers' problem behaviors showed significant relationship with the dependent variable. Among the variables, amount of care (beta=.361, $p<.05$) was the most important factor determining the caregivers' attitude toward caregiving. Unexpectedly, the caregivers who provided more care reported more positive attitude toward caregiving. The quality of social support (beta=.335, $p<.05$) was a second significant predictor of Korean American dementia caregivers' attitude toward caregiving, confirming the importance of social support in family caregiving cross-culturally. Additionally, the care receivers' problem behavior (beta=.-.231, $p<.05$) was significant variable in the final regression model. The caregivers with care recipients who represent less problem behaviors have more positive attitude toward caregiving.

Stressor factors

The addition of stressor factors including care receivers' problem behaviors, amount of daily care, and duration of caregiving, did not contribute to the overall relationship with Korean American dementia caregivers' attitude toward caregiving. The increase of R^2 was only 4%. Even though the stressor factors did not contribute to explanation of the Korean American dementia caregivers' attitude toward caregiving significantly, the amount of daily care a caregiver provides and care receiver's problem behaviors were significant determinants of caregivers' attitude toward caregiving. Consistent with previous research (Gaugler, Kane, Kane, & Newcomer, 2005; Hooker et al., 2000), care receivers' problem behaviors showed negative relationship with caregivers' positive attitude toward caregiving. However, the positive relationship between amount of care per day and positive attitude toward caregiving is counter to most research in this area (Covinsky et al. 2003; Ory et al., 1999).

This finding is noteworthy because amount of care had negative correlation with caregiver's attitude toward caregiving (r=-.157, p=.156) in the bivariate correlation test. However, in the final model with cultural factors, the result shows significant inverse relationship where the caregivers with higher amount of care show positive attitude toward caregiving. Additional interaction tests among the amount of care and cultural factors did not explain the complex result. Despite of the significant relationship, it is premature to conclude that more care given causes positive caregiver's attitude, since this study was conducted with small samples within limited immigrant population. Further examination of the relationship between the amount of care and immigrant caregiver's attitude toward caregiving in the context of social support and culture needs to be

conducted.

Social support factors

The result of this study confirms that social support is a significant cross-culturally factor. Social support factors including amount and of social support explained significant amount of Korean American dementia caregiver's attitude toward caregiving. The addition of social support factors significantly increase the R^2, where the social support factors accounted for 13% more of the variances of the model. However, among the two social support variables, the amount of social support (beta=.115, *p*=.359) was not significantly related to the Korean American dementia caregivers' attitude toward caregiving, whereas quality of social support (beta=.335, *p*=.008) showed a significant relationship with the dependent variable.

In her literature review on social support and caregiver burden, Vrabec (1997) found that quality of social support showed consistent positive relation to the family caregivers' burden. She argued that measuring amount, quality, and satisfaction of social support can enhance construct validity of study results. Social support, specially quality of social support is well known protective factor for dementia caregivers' overall well-being. Chappell and Reid (2002) also found that perceived social support is directly and positively correlated to caregiver's well-being. In their study of protective factors on caregivers' well-being, among four variables, perceived social support, frequency of getting a break, formal service use, and self-esteem, only perceived social support was a significant mediator between stressor and caregiver's well-being. Stuckey and Smyth (1996) also argued that subjective perception of adequacy of social tie was more relevant to understanding health outcomes of dementia caregivers than is the amount of social ties.

Cultural factors

The addition of cultural factors did not contribute significantly to the overall relationship with the caregivers' attitude toward caregiving, where it increased R^2 by 8%. None of the variables among the cultural factors--- years in the U.S., acculturation, familism, and filial piety--- were a significant predictor of Korean American dementia caregivers' attitude toward caregiving. Aranda and Knight (1997)'s 'sociocultural stress and coping model', which argues that "ethnicity and culture play a significant role in the stress and coping process of caregivers to the elderly as a result of a) a differential risk for specific health disorders and disability, b) variation in the appraisal of potential stressors, and c) the effect on stress-mediating variables such as social support and coping" (p. 343) did not explain Korean American dementia caregivers' attitude toward caregiving.

Even though the variable, years in the U.S., was not significant predictor of Korean American dementia caregivers' attitude toward caregiving at p=.05, it close to significant, beta=-.238, t(61)=-1.840, p=.071. Considering the small sample size (N=77), years in the U.S. can be regarded as a potential predictor of the Korean American dementia caregivers' attitude toward caregiving. Level of acculturation, which was expected to be a significant variable in the model, did not contribute significantly to Korean American caregivers' attitude toward caregiving. As Kim et al. (2005) say, it is not simple task to measure acculturation accurately because self-report is subjective. In their study, Korean Americans' level of acculturation did not buffer the negative affect from acculturative stress on depression. As the research on immigrant populations increase, the instrumentation of acculturation or culture should be studied further in both qualitative and quantitative ways.

Contrary to the preassumption, filial piety and familism did not explain the Korean American dementia caregivers' attitude toward caregiving. As Knight et al. (2002) describe, familism or cultural values may be interesting factors not operating factors, which determine dementia caregivers' mental health. In their multiracial caregiving study, familism was not significantly related to Korean American dementia caregivers' depression and anxiety. Korean American caregivers showed higher familism and higher anxiety compared to caregivers in other social groups. In the analyses with other racial groups, the relationship between familism and caregivers' mental health showed inconsistent patterns. Even though the role of culture on caregivers' mental health is still confusing, it is early to conclude culture as less an important factor considering previous research results on culture as s significant factor (Janevic, & Connell, 2001; Pinquart & Sorenson, 2005). More rigorous and diverse future researches can explain role of culture in dementia caregiving among minority families.

Culture is a fundamental system of shared knowledge that imbues social acts with meaning (D'Andrade, 1984). A pattern of social support is considered part of a culture. In this study, social support contributed significantly to the caregivers' attitudes toward caregiving, whereas cultural factors did not seem to. However, the result should be interpreted cautiously since the separation of social support and culture is arbitrary. Social support can belong to a culture or can be part of culture since dynamics of social support is affected by culture. As Dressler, Balieiro, & Santos (1997) argue, social support is constructed in cultural systems and cultural dimension of social support should be distinguished from individual reporting of perceived social support. They found that cultural consonance of social support, the way of seeking social support from relatives,

friends, or further networks, is more important determinant of health outcomes than perceived social support.

Discussion of Exploratory Comparison of Spouse caregivers and Non-spouse caregivers

Additional separate hierarchical regression analyses revealed discrepancy of predictors of attitude toward caregiving between spouse caregivers group and nonspouse caregivers group. The adjusted R^2 from spouse caregivers and nonspouse caregivers were 85% and 33%, respectively.

For the spouse caregivers, the demographic factors accounted for 50% of the variance of the dependent variable. Among the demographic factors, income (beta=.772, $t(30)= 5.855$, $p<.01$) and education (beta=.363, $t(30)= 2.368$, $p<.05$) were significant predictors of Korean American dementia caregivers. Stress factors did not produce a significant contribution in prediction of variance. As expected, social support factor significantly contributed to the explanation of the spouse caregivers' attitude toward caregiving. Quality of social support (beta=.686, $t(30)= 4.196$, $p<.01$) was an important predictor of the spouse caregivers' attitude toward caregiving. Even though cultural factors failed to explain additional significant variances, predictors which were close to significant, years in the U.S. (beta=-.278, $t(30)=-1.958$, $p=.069$) and familism (beta= .225, $t(30)=1.842$, $p=.085$), should receive more attention in future research, considering the low sample size ($N=30$). Among the various variables, income was the most important factor (beta=772, $t(15)=5.855$, $p< .01$), followed by quality of social support (beta=.686, $t(15)= 4.196$, $p< .01$) and education (beta=.363, $t(15)=2.368$, $p<.05$).

The result of the analysis of non-spouse sample shows a different pattern. Among the three factors including stressor factors, social support factors, and cultural factors, none of them significantly increased the explanation of the dependent variable. With all predictors in the equation, the model accounted for only 33% of variances in Korean American non-spouse dementia caregivers' the attitude toward caregiving. In sum, the adjusted R^2 from two caregiver groups are significantly different (85% vs. 33%), referring the discrepancy of predictors of attitude toward caregiving experiences between the two groups. The result implies that the model tested in this study can not be applied to general caregiving populations because it does not explain the immigrant non-spouse caregivers' attitude toward caregiving. In other words, the model, which include stressor factors, social support factors, and cultural factors, should be used in explaining immigrant spouse caregivers' attitude toward caregiving

The non-spouse caregivers, mainly children in this analysis, were young, had higher income, and were highly acculturated into the U.S. According the result of this study, the children caregivers' family and caregiving dynamics are different from the one of their parents' generation. Kim and Theis (2000) support the existence of difference between Korean spouse caregivers and children caregivers. Most of the time, adult children caregivers are required to work long hours to make enough income to support the immigrant family while the spouse caregivers stay home and take care of grandchildren. In their analysis, the spouse caregivers had much less chances to have social support than children caregivers. The spouse caregivers revealed that they felt living in different world from their children' where their children have been acculturated into the new society. Even though they immigrated from same country and have same

lengths of stay, the two groups of caregivers have been through different experience of caregiving. Considering the result of this study and Kim and Theis's (2000) study, it may be premature to collapse the two different caregiving groups, spouse groups and non-spouse groups, into one model to explain the immigrant families' caregiving dynamics.

Limitations of the Study

Even though the results of this study provide critical information on Korean American population to mental health professions and researchers, there are several limitations to this study. One of the major issues in this study was small sample size (N=77). The small sample size can impact the statistical test by making it insensitive (Hair et al., 1998). However, the statistical power analysis, a test on probability that statistical significance will be signified if there is one (Hair et al., 1998), offers promising results. With the sample of 77 and 16 independent variables, R^2 value of approximately .24 achieved observed power of .82 (Soper, 2007), which is higher than the acceptable power level of .80.

Since the sample relied on referred caregivers by the social workers in each agencies and volunteers, the samples did not represent Korean American dementia caregivers in the U.S. In this circumstance, the researcher should be cautious in interpreting the result since there is a possibility of selection bias, the participants who volunteered for the research are more active and positive, and social desirability bias, tendency to say things that will make the respondents look good (Rubin, & Babbie, 2001). Limited sampling site was another drawback of this study. The sampling was mainly done in Los Angeles, Chicago, and Houston for 6 months through social workers in

Korean or Asian agencies. One of the solutions to increase sample size and include more representative site is finding gatekeepers in Korean American society in the U.S. and receive their formal and informal support. More detailed discussion on contacting gatekeepers will be illustrated in the section of future research.

Finally, this was a cross-sectional study which did not show the causality among the independent variables and the dependent variable. It was not possible to ascertain whether the independent variables affect the caregivers' attitude toward caregiving or the dependent variable affect independent variables. Longitudinal data with same population can be expected to measure the causal relationship among minority caregivers' cultural variables and their attitude toward caregiving.

Social Work Practice Implications

Despite the growing body of literature on the coexistence of positive and negative aspects of dementia caregiving, many researchers continue to focus on negative aspects of dementia caregiving, while mental health practitioners far too frequently ignore the positive aspect of dementia caregiving (Greene, [1986] 2000). Resilience is an important factor determines immigrant families' mental and physical health. As Aroian and Norris (2000) showed in their study, resilience is a factor that decreases the risk of depression among immigrants, suggesting that strengths-based practice interventions that foster resilience may be beneficial among caregivers.

There is a suggestion from this study that social support may benefit minority dementia caregivers. As proven in this study, social support was cross-culturally significant protector of dementia caregivers' mental health. Moreover, quality of social

support was more important than amount of social support in dementia caregiving. Future interventions should focus on increasing or enhancing quality of social support among minority caregivers and families. Having satisfactory social support can make caregivers feel protected and resilient. It will provide minority caregivers opportunity to stand up and search for encouragement and more formal support system.

Social Work Policy Implications

As the population of minority older adults grows fast, family caregivers for minority older adults become more significant. They are the backbone of national health care. This pool of informal caregivers is seen as increasingly important to the overall well-being of people with dementia at a time when the cost of health care continues to increase. Policy makers need to acknowledge the importance of cultural diversity in current multi-racial society. Bureaucratic administration and policy can not see reality of the diverse caregiving population. First of all, it is necessary to increase of bilingual staff in healthcare system and government agencies. Language is an essential component of minority clients' communication within the healthcare system, which bridge the client and his/her family into the quality care and public resources (Padilla & Villalobos, 2007). Even if the professionals do not speak a certain minority language, they should acknowledge the culture at least. According to the result of this study, spouse caregivers have less positive attitude toward caregiving compared to the children caregivers. It is imperative to increases the policies and resources which help them maintain their mental health and take care of their love one. There are many older Korean dementia caregivers who can't speak English and totally depend on their children. Many of them do not co-

reside with their children in which case the older caregivers do not have access to societal support. Korean speaking social workers do jobs on reading and writing letters for the older Korean caregivers are extremely limited. The increase of bilingual social workers and staff for non-English speaking spouses is urgent.

Caregivers for early stage of dementia patients are easily frightened by the changes they experience. As Tebb and Jivanjee (2000) explain, the new caregivers with no information on the disease just isolate themselves and their spouses from the society. The isolation can be deteriorated by the lack of appropriate social network and resources. Minority caregivers do not find it easy to approach to the community resources and get help for their family member's disease. Language barrier and cultural barrier which stems from their tendency not to disclose their family member's dementia hinder the minority caregiver to ask help outside. Social network and community resources network for minorities should be strengthened to approach the hidden and withdrawn minority caregivers.

A key approach to access minority caregivers and their families is to go through community channels (Padilla, & Villalobos, 2007). Local churches or day centers for minority older adults for minority families play as a hub of the information and support for the minority dementia caregiving families. Immigrant families say that they benefit from their friends and family who share similar cultural value and background. The support from those support networks is a core component for being bicultural, state of meeting the demands from two different cultures successfully in foreign country (LaFromboise, Coleman, & Gerton, 1993). Social workers in the Adult Day Health Centers in Los Angeles also disclosed that that the Korean American older adult

caregivers only come to the Korean centers to get help without seeking formal social support or community resources.

Future Research

In future researches, discrepancy of predictors of attitude toward caregiving in both spouse and non-spouse group should be investigated further. The proposed model explained spouse caregivers group's attitude toward caregiving only. Even though they immigrated have same immigrant history and have same lengths of stay, the two groups of caregivers share different experience of caregiving. Adult children caregivers participate in society more and become acculturated into the U.S faster than their parents. They have different level and quality of social support. The heterogeneity should be considered in next study with minority caregiving families.

Despite of several significant findings, some of the complex relationships among the variables, such as positive relationship between the amount of care and caregivers' attitude toward caregiving remain unanswered. In future research, qualitative research method, such as focus group can be utilized to investigate the complex dynamics of dementia caregiving in minority culture. Most of Korean social workers in communities have MSW degree along with research knowledge. They understand the nature of qualitative research and can be cooperative in the research process. Even though the number of dementia caregivers support group for Korean population in the U.S. is limited, the group participants can provide imperative ideas on dementia caregiving in minority culture. Once the support groups are utilized in various ways to benefit Korean population in the U.S. social work research and practice for minority population will

develop more.

Korean American society is relative closed system as many other minority communities are. It is not an easy job to contact Korean or other minority caregivers with dementia patients due to the stigmatization of the disease in minority culture. The minority populations generally get along around local churches and senior centers. To find and get the gate keepers in each minority community will increase the success rate in inclusion of minority dementia caregivers. The gate keepers can also be at the center of information for the minority caregivers. The gate keeper who has authority in each minority community can open the door for the mental health researcher and also provide resources to the caregiver.

Trust and continuous connection with the community are central in recruitment in the research with minority population. Many studies have noted that minority elderly suffer more negative experiences than the white elderly in the U.S. (Yoo & Sung, 1997). For Asians Americans who immigrated to the U.S. with language and cultural barriers, this would lead to enormous negative life experiences. Such a situation in which the Asian elderly found themselves might be labeled as 'quadruple jeopardy' (being old, being female, being a minority, and having language and cultural barrier) (Yoo & Sung, 1997). The only way to decrease their anxiety is to establish a trustful connection between researchers and minority caregivers.

Conclusions

This study took into account of range of characteristics to investigate the influence of stressor, social, and cultural factors on Korean American dementia caregivers' attitude toward caregiving. Children caregivers showed more positive attitude toward caregiving than spousal caregiving. Contrary to the assumption, there was no interaction effect between social support and acculturation on caregivers' attitude toward caregiving. The study hypothesized that stressor factors, social support factors, and cultural factors would significantly determine the caregivers' attitude. Only social support factors significantly predicted Korean American dementia caregivers' attitude toward caregiving. Among the variables, the amount of caregiving was the most important factor determining the Korean American dementia caregiver's attitude toward caregiving, followed by quality of social support and care receiver's problem behaviors.

Comparison of beta coefficients from the spouse caregiver group and non-spouse caregiver group revealed the discrepancy of predictors of Korean American caregivers' attitude toward caregiving between the two caregiving groups. It is suggested the model should be applied to immigrant spouse caregiver groups only. The results of this study imply the importance of incorporating cultural diversity in social policy. Inclusion of contents on increasing and enhancing quality of social support is recommended for social work practices with Korean American dementia caregivers.

APPENDIX A

English Version of Questionnaires

*Thank you for taking some time to participate in this study. The following survey contains questions regarding your general background, acculturation, your care receiver's problem behaviors, social support, familism, and your attitude toward caregiving. In this survey, the care receiver refers to the person you are caring for.

A. Demographic Questions[1]

The following questions (#1- 9) are about your general background.

1. What is your birth year? 19_____What month? _____

2. What is your gender?

1) Male
2) Female

3. What is your receiver' birth year? 19_____ What month? _____

4. What is his/her gender?

1) Male
2) Female

5. What is your annual family income before taxes? (Include all salaries, wages, pensions, interest, and all other income)

1) *Less than $5000*
2) *$5000-$9,999*
3) *$10,000-$14,999*
4) *$15,000-$19,999*
5) *$20,000-$29,999*
6) *$30,000-$39,999*
7) *$40,000-$49,999*
8) *$50,000-$59,999*
9) *$60,000-$69,999*
10) *$70,000 or more*

[1] Demographic questions are created by the author.

6. What is your highest level of education that you have completed

1) No Education
2) Elementary School
3) Middle School
4) High School
5) Some College/Associate degree
6) College Graduate
7) Doctoral Degree (PhD, MD, EdD., D.V.M., DDS., JD, etc.)

7. What is your relationship to your care receiver?

1) Spouse
2) Daughter
3) Daughter-in-law
4) Son
5) Other

8. Are you a major caregiver for this person?

1) Yes
2) No
3) Other*(Pleas specify: _____)*

9. Do you live with the person you care for?

1) Yes
2) No
3) Other *(Please specify: _____)*

10. On a typical day, how many hours do you spend directly caring for or supervising the care receiver? _____ hours

11. How long have you been caring for this person? ___ Year(s) ___ Month(s)

B. Acculturation Scale[2]

12. Were you born in the United States?

1) Yes (Go to 10-1) 2) No (Go to 10-2)

12-1. Where were you parents born? Father_____Mother

12-2. How many years have you lived in the United States?_____Year(s)

13. What language do you generally speak?

1) Only Korean
2) More Korean than English
3) Both equally
4) More English than Korean
5) Only English

14. What are your food preferences?

1) Korean food only
2) Mostly Korean food, some American food
3) Both equally
4) Mostly American food, some Korean food
5) American food only

15. Who are your close friends?

1) All Koreans
2) More Koreans than Americans
3) About half and half
4) More Americans than Koreans
5) All Americans

[2] Adapted from:
Marin, G., Sabogal, F., Marin, B. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9*(2), 183-205.
Sung, K. (1995). Measures and dimensions of filial piety in Korea. *The Gerontologist, 35*(2), 240-247.

16. How do you rate your acculturation (westernization)?

1) Not at all westernized
2) Somewhat westernized
3) Neutral
4) Pretty much westernized
5) Strongly westernized

* The following two questions are about your perception of filial piety. (Filial piety commonly refers to children's respect and obligation to their parents).

15. Young people should provide physical and financial sacrifice themselves for parents.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree
4	3	2	1	0

16. Young people should show respect for parents.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree
4	3	2	1	0

C. <u>Revised Memory and Behavior Problems Checklist</u>[3]

*The following is a list of problems patients sometimes have. Please indicate if any of these problems have occurred during **<u>the past week</u>**.

1. Within the past week, has care receiver been asking the same question over and over?
   1) Yes 2) No

2. Within the past week, has care receiver had trouble remembering recent events (e.g., items in the newspaper or on TV)?
   1) Yes 2) No

3. Within the past week, has care receiver had trouble remembering significant events?
   1) Yes 2) No

4. Within the past week, has care receiver been losing or misplacing things?
   1) Yes 2) No

5. Within the past week, has care receiver been forgetting what day it is?
   1) Yes 2) No

[3] Adapted from: Teri, L., Traux, P., Logsdon, R., Uomoto, J., Zarit, S., & Vitaliano, P. (1992). Assessment of behavioral problems in dementia: The revised memory checklist. *Psychology and aging, 7*(4), 622-631.

6. Within the past week, has care receiver been starting things but not finishing them?
   1) Yes 2) No

7. Within the past week, has care receiver had difficulty concentrating on a task?
   1) Yes 2) No

8. Within the past week, has care receiver been destroying property?
   1) Yes 2) No

9. Within the past week, has care receiver been doing things that embarrass you?
   1) Yes 2) No

10. Within the past week, has care receiver been waking you or other family members at night?
   1) Yes 2) No

11. Within the past week, has care receiver been talking loudly and rapidly?
   1) Yes 2) No

12. Within the past week, has care receiver appeared anxious or worried?
   1) Yes 2) No

13. Within the past week, has care receiver been engaging in behavior that is potentially dangerous to him/herself or others?
   1) Yes 2) No

14. Within the past week, has care receiver threatened to hurt him/herself?
   1) Yes 2) No

15. Within the past week, has care receiver threatened to hurt others?
   1) Yes 2) No

16. Within the past week, has care receiver been aggressive to others verbally?
   1) Yes 2) No

17. Within the past week, has care receiver appeared sad or depressed?
   1) Yes 2) No

18. Within the past week, has care receiver been expressing feelings of hopelessness or sadness about the future (Such as, “Nothing worthwhile ever happens”, or “I never do anything right”)?
   1) Yes 2) No

19. Within the past week, has care receiver been crying and tearful?
   1) Yes 2) No

20. Within the past week, has care receiver been commenting about the death of him/herself or other (such as, “Life isn’t worth living”, or “I’d be better off dead”)?
   1) Yes 2) No

21. Within the past week, has care receiver been talking about feeling lonely?
1) Yes 2) No

22. Within the past week, has care receiver made comments about feeling worthless or being a burden to others?
1) Yes 2) No

23. Within the past week, has care receiver made comments about feeling like a failure or about not having any worthwhile accomplishments in life?
1) Yes 2) No

24. Within the past week, has care receiver been arguing, irritable, and /or complaining?
1) Yes 2) No

D. <u>Social Support Scale</u>[4]

* Now I would like you to answer the following questions regarding how much help and support you receive from family and friends.

1. How many relatives other than the care receiver do you see or hear from at least once a month? (Include in-laws with relatives)

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

2. Tell me about the relative with whom you have the most contact other than the care receiver. How often do you see or hear from that person?

0 = < monthly
1 = monthly
2 = a few times a month
3 = weekly
4 = a few times a week
5 = daily

[4] Adapted from:
Lubben, J. (1988). Assessing social networks among elderly populations. *Family & Community Health, 11*(3), 42-52.
Krause, N., & Markides, K. (1990). Measuring social support among older adults. International Journal of Aging and Human Development, 30(1), 37-53.

3. How many relative other than the care receiver do you feel close to? That is, how many of them do you feel at ease with, can talk to about private matters, or can call on for help?

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

4. Do you have any close friends? That is, do you have any friends with whom you feel at ease, and can talk to about private matters, or can call on for help? If so, how many?

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

5. How many of these friends do you see or hear from at least once a month?

0 = zero
1 = one
2 = two
3 = three or four
4 = five to eight
5 = nine or more

6. Tell me about the friend with whom you have the most contact. How often do you see or hear from that person?

0 = < monthly
1 = monthly
2 = a few times a month
3 = weekly
4 = a few times a week
5 = daily

7. When you have an important decision to make, do you have someone you can talk to about it?

Always	Very often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

8. When other people you know have an important decision to make, do they talk to you about it?

Always	Very often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

9. Overall, how satisfied have you been in the last month with the help you have received transportation, housework and yardwork, and shopping, etc.?

Very	Moderately	A little	Not at all
3	2	1	0

10. In the past month, how satisfied have you been with the support received during difficult times such as comfort from others, how others have listened, and interest and concern from others?

Very	Moderately	A little	Not at all
3	2	1	0

11. Overall, how satisfied in the last month have you been with the suggestions, clarifications, and sharing of similar experiences you have received from others?

Very	Moderately	A little	Not at all
3	2	1	0

E. **Familism Scale**[5]

*Next is a list of issues concerning family *in general, not your own*. Using the scale (0 to 4) below, respond to all of the questions on the basis of your own true beliefs without consulting any other persons.

4= Strongly agree
3= Agree
2= Undecided
1= Disagree
0= Strongly disagree

1. A person should always support his uncles or aunts if they are in need.	4	3	2	1	0
2. Children below 18 should give almost all their earnings to their parents.	4	3	2	1	0
3. The family should consult close relatives (uncles, aunts, first cousins) concerning important decisions.	4	3	2	1	0
4. Children below 18 should almost always obey their older brothers and sisters.	4	3	2	1	0
5. A person should always consider the needs of his family as a whole more important than his own.	4	3	2	1	0
6. At least one married child should be expected to live in the parental home.	4	3	2	1	0
7. A person should always be expected to defend his family against outsiders even at the expense of his own personal safety.	4	3	2	1	0
8. The family should have the right to control the behavior of each of its members completely.	4	3	2	1	0
9. A person should always support his parents-in-law if they are in need.	4	3	2	1	0
10. A person should always avoid every action of which his family disapproves.	4	3	2	1	0

[5] Source: Bardis, P. (1959b). A familism scale. *Marriage & Family Living, 21,* 340-341

4= Strongly agree
3= Agree
2= Undecided
1= Disagree
0= Strongly disagree

11. A person should always share his home with his uncles, aunts, or first cousins if they are in need.	4	3	2	1	0
12. A person should always be completely loyal to his family.	4	3	2	1	0
13. The members of a family should be expected to hold the same political, ethical, and religious beliefs.	4	3	2	1	0
14. Children below 18 should always obey their parents.	4	3	2	1	0
15. A person should always help his parents with the support of his younger brothers and sisters if necessary.	4	3	2	1	0
16. A person should always share his home with his parent-in-law if they are in need.	4	3	2	1	0

F. Finding Meaning Through Caregiving Scale[6]

*****This last section is about your opinions and feelings about yourself, your care receiver, and your caregiving experience. Please, indicate the extent to which you agree or disagree with the statement.

4= Strongly agree
3= Agree
2= Undecided
1= Disagree
0= Strongly disagree

1. I miss the communication and companionship that my family member and I had in the past.	4	3	2	1	0
2. I miss my family member's ability to love me as he/she did in the past.	4	3	2	1	0

[6] Source: Farren, C., Miller, B., Kaufman, J., Donner, E., & Fogg, L. (1999). Finding meaning through caregiving: Development of an instrument for family caregivers of persons with Alzheimer's disease.
Journal of clinical psychology, 55(9), 1107-1125.

4= Strongly agree
3= Agree
2= Undecided
1= Disagree
0= Strongly disagree

3. I am sad about the mental and physical changes I see in my relative.	4	3	2	1	0
4. I miss the little things my relative and I did together in the past.	4	3	2	1	0
5. I am sad about losing the person I once knew.	4	3	2	1	0
6. I miss not being able to be spontaneous in my life because of caring for my relative.	4	3	2	1	0
7. My situation feels endless.	4	3	2	1	0
8. I enjoy having my relative with me: I would miss it if he/she were gone.	4	3	2	1	0
9. I count my blessings.	4	3	2	1	0
10. Caring for my relative gives my life a purpose and a sense of meaning.	4	3	2	1	0
11. The Lord won't give you more than you can handle.	4	3	2	1	0
12. I miss not having more time for other family members and/or friends.	4	3	2	1	0
13. I have no hope; I am clutching at straws.	4	3	2	1	0
14. I cherish the past memories and experiences that my relative and I have had.	4	3	2	1	0
15. I am a strong person.	4	3	2	1	0
16. Caregiving makes me feel good that I am helping.	4	3	2	1	0
17. I believe in the power of prayer: without it I couldn't do this.	4	3	2	1	0
18. I miss our previous social life.	4	3	2	1	0

4= Strongly agree
3= Agree
2= Undecided
1= Disagree
0= Strongly disagree

19. I have no sense of joy.	4	3	2	1	0
20. The hugs and "I love you" from my relative make it worth it all.	4	3	2	1	0
21. I'm a fighter.	4	3	2	1	0
22. I am glad I am here to care for my relative.	4	3	2	1	0
23. I believe that the Lord will provide.	4	3	2	1	0
24. I miss not being able to travel.	4	3	2	1	0
25. I wish I were free to lead a life of my own.	4	3	2	1	0
26. Talking with others who are close to me restores my faith in my own abilities.	4	3	2	1	0
27. Even though there are difficult things in my life, I look forward to the future.	4	3	2	1	0
28. Caregiving has helped me learn new things about myself.	4	3	2	1	0
29. I have faith that the good Lord has reasons for this.	4	3	2	1	0
30. I miss having given up my job or other personal interests to take care of my family member.	4	3	2	1	0
31. I feel trapped by my relative's illness.	4	3	2	1	0
32. Each year, regardless of the quality, is a blessing.	4	3	2	1	0
33. I would not have chosen the situation I'm in, but I get satisfaction out of providing care.	4	3	2	1	0
34. We had goals for the future but they just folded up because of my relative's dementia.	4	3	2	1	0
35. God is good.	4	3	2	1	0

4= Strongly agree
3= Agree
2= Undecided
1= Disagree
0= Strongly disagree

36. I miss my relative's sense of humor.	4	3	2	1	0
37. I wish I could run away.	4	3	2	1	0
38. Every day is blessing.	4	3	2	1	0
39. This is my place: I have to make the best out of it.	4	3	2	1	0
40. I am much stronger that I think.	4	3	2	1	0
41. I feel that the quality of my life has decreased.	4	3	2	1	0
42. I start each day knowing we will have a beautiful day together.	4	3	2	1	0
43. Caregiving has made me a stronger and better person.	4	3	2	1	0

***Thank you for your time. Please place this survey in the envelope provided and drop it in the mail at your earliest convenience.**

APPENDIX B

Korean Version of Questionnaires

* 본 연구에 참여해 주셔서 감사합니다. 아래의 설문지에는 귀하의 일반적 배경, 문화변동성, 현재 수발을 받으시는 분의 문제 행동들, 사회적 지지, 가족주의, 그리고 귀하의 수발에 대한 태도등에 대한 질문들이 포함되어 있습니다. 본 연구에서 환자는 현재 수발을 받고 계신 분을 뜻합니다.

아래의 질문들 (1~9번)은 귀하의 일반적 배경에 관한 질문입니다.

1. 귀하는 언제 태어나셨습니까? 19_____년 _____월

2. 귀하의 성별은 무엇입니까?

1) 남자
2) 여자

3. 환자분 께서는 언제 태어나셨습니까?
19_____년 _____월

4. 그분의 성별은 무엇입니까?

1) 남자
2) 여자

5. 귀하 가족의 세금 전 일년 총 수입은 얼마입니까 (연봉, 연금, 은행이자 등을 포함한 모든 수입)?

1) *5000 불 미만*
2) *5000 불~9,999 불*
3) *10,000 불-14,999 불*
4) *15,000 불-19,999 불*
5) *20,000 불-29,999 불*
6) *30,000 불-39,999 불*
7) *40,000 불-49,999 불*
8) *50,000 불-59,999 불*
9) *60,000 불-69,999 불*
10) *70,000 이상*

6. 귀하의 최종 학력은 무엇입니까?

1) 무학
2) 초등(국민)학교
3) 중학교
4) 고등학교
5) 2년제 대학 졸업
6) 4년제 대학 졸업
7) 대학원 이상 졸업 (Ph.D, MD, EdD., D.V.M., DDS., JD, 등등.)

7. 귀하의 환자와의 관계는 어떻게 되시나요?

1) 배우자
2) 딸
3) 며느리
4) 아들
5) 기타

8. 귀하께서 그 환자분의 주 수발자이십니까?

1) 예
2) 아니오
3) 기타 (구체적으로: _____)

9. 현재 환자분과 같이 사시나요?

1) 네
2) 아니오
3) 기타*(구체적으로: _____)*

10. 하루평균 몇시간 정도를 환자분을 돌보시는데 쓰시나요? _____ 시간

11. 얼마동안 환자분을 돌보시고 계십니까? _____ 년 _____ 개월

12. 미국에서 태어나셨나요?

1) 예 (10-1으로 가세요) 2) 아니오 (10-2으로 가세요)

10-1. 귀하의 부모님을 어디서 태어나셨나요? 아버지____어머니

10-2. 미국에 몇년동안 거주하시고 계십니까? _____년

13. 귀하께서 주로 사용하시는 언어는 무엇입니까?

1) 한국말만 사용
2) 대부분 한국말 사용, 가끔 영어 사용
3) 한국말과 영어 비슷한 정도로 사용
4) 대부분 영어 사용, 가끔 한국말 사용
5) 영어만 사용

14. 귀하께서는 주로 어떤 음식들을 드십니까?

1) 한국음식만 먹음
2) 대부분 한국음식, 가끔 서양음식 먹음
3) 한국음식과 서양음식 비슷한 정도로 먹음
4) 대부분 미국음식, 가끔 한국음식 먹음
5) 미국음식만 먹음

15. 귀하와 가깝게 지내는 친구들은 누구입니까?

1) 모두 한국인들
2) 대부분 한국인들과 몇몇 미국인들
3) 한국인과 미국인들 비슷한 정도
4) 대부분 미국인들과 몇몇 한국인들
5) 모두 미국인들

16. 귀하는 귀하 자신의 서양화 혹은 문화변용인식 (acculturation)? 을 어떻게 평가하십니까?

1) 전혀 서양화 되지 않았음
2) 어느정도 서양화 되었음
3) 보통이다.
4) 꽤 서양화 되었음
5) 아주 서양화 되었음

*아래는 효에 관한 귀하의 생각에 관한 질문입니다. (보통 부모에 대한 자녀의 존경과 의무등을 효라 칭합니다).

17. 젊은이들은 부모들에게 육체적과 재정적인 희생을 해야한다.

매우 동의	어느정도 동의	잘 모르겠음	어느정도 반대	매우 반대
4	3	2	1	0

18. 젊은이들은 부모들에게 존경을 보여야한다.

매우 동의	어느정도 동의	잘 모르겠음	어느정도 반대	매우 반대
4	3	2	1	0

*아래는 현재 귀하의 수발을 받으시는 가족 (환자)께서 보이시는 문제 행동들에 관한 질문입니다. 지난주 동안 이 행동들 중 어떤 것이라도 나타났다면 표시해 주십시오.

1. 지난 일주일 동안 가족 (환자) 께서 같은 질문을 여러번 한 적이 있습니까?
   1) 예 2) 아니오

2. 지난 일주일 동안 가족 (환자)께서 최근에 일어난 일들 (예를 들자면 신문이나 TV에 보도된 뉴스)을 기억하는데 어려움을 겪으신 적이 있습니까?
   1) 예 2) 아니오

3. 지난 일주일 동안 가족 (환자)께서 중요한 일을 기억하시는데 어려움을 겪으신 적이 있으셨습니까?
   1) 예 2) 아니오

4. 지난 일주일 동안, 가족 (환자)께서 물건을 잃어 버리시거나 잘못된 곳에 두곤 하셨습니까?
   1) 예 2) 아니오

5. 지난 일주일 동안 가족 (환자)께서 오늘이 무슨요일인지 잊어버리신 적이 있습니까?
   1) 예 2) 아니오

6. 지난 일주일 동안 가족 (환자)께서 무언가를 시작했지만 끝을 내지 못하신 적이 있습니까?
   1) 예 2) 아니오

7. 지난 일주일 동안 가족 (환자)께서 집중에 어려움을 겪은 적이 있습니까?
1) 예 2) 아니오

8. 지난 일주일 동안 가족 (환자)께서 물건을 부순 적이 있습니까?
1) 예 2) 아니오

9. 지난 일주일 동안 가족 (환자)께서 귀하를 난처하게 만드는 일을 하신 적이 있습니까?
1) 예 2) 아니오

10. 지난 일주일 동안 가족 (환자)께서 귀하나 다른 가족들을 밤중에 깨운 적이 있습니까?
1) 예 2) 아니오

11. 지난 일주일 동안 가족 (환자)께서 시끄럽고 빨리 이야기 한 적이 있습니까?
1) 예 2) 아니오

12. 지난 일주일 동안 가족 (환자)께서 불안하거나 걱정이 많아 보인 적이 있습니까?
1) 예 2) 아니오

13. 지난 일주일 동안 가족 (환자)께서 본인에게 위험할 수 있는 행동들을 하신 적이 있습니까?
1) 예 2) 아니오

14. 지날 일주일 동안 가족 (환자)께서 자신을 해하겠다고 위협한 적이 있습니까?
1) 예 2) 아니오

15. 지난 일주일 동안 가족 (환자)께서 다른 사람을 해하겠다고 위협한 적이 있습니까?
1) 예 2) 아니오

16. 지난 일주일 동안, 가족 (환자)께서 다른 사람에게 공격적인 말을 한 적이 있습니까?
1) 예 2) 아니오

17. 지날 일주일 동안 가족 (환자)께서 슬프거나 우울해 보인 적이 있습니까?
1) 예 2) 아니오

12. 지난 일주일 동안 가족 (환자)께서 미래에 대해 희망적이지 않거나 슬프게 이야기 했습니까 (예를 들자면 “어떤 것도 가치가 있지 않다” 거나 “나는 잘한게 하나도 없다”)?
1) 예 2) 아니오

19. 지날 일주일 동안 가족 (환자)께서 많이 우신 적이 있습니까?
1) 예 2) 아니오

20. 지날 일주일 동안 가족 (환자)께서 본인이나 다른 사람의 죽음에 대해서 이야기 하곤 했습니까 (예를 들자면 “인생은 가치가 없다” 던가 “나는 죽는 게 낫다” 등)?

1) 예 2) 아니오

21. 지난 일주일 동안 가족 (환자)께서 외로움에 대해 이야기 한 적이 있습니까?

1) 예 2) 아니오

22. 지난 일주일 동안 가족 (환자)께서 본인이 무가치하고 다른 사람들에게 짐이 된다고 이야기 한 적이 있습니까?

1) 예 2) 아니오

23. 지난 일주일 동안 가족 (환자)께서 본인이 인생을 실패했고 가치있는 일을 하나도 하지 않았다고 이야기 한 적 있습니까?

1) 예 2) 아니오

24. 지난 일주일 동안 가족 (환자)께서 논쟁적이고 초조하며 불평을 하곤 했습니까?

1) 예 2) 아니오

*이제 귀하께서 주위의 가족과 친구들로 부터 받은 도움과 지지에 대해 답해 주십시오.

1. 지난 한달동안 몇명의 친인척 (치매 환자분 제외)을 만나거나 그들로 부터 소식을 들었습니까?

0 = 없음
1 = 한명
2 = 두명
3 = 세명~네명
4 = 다섯명~여덟명
5 = 아홉명 이상

2. 가장 연락을 많이 하는 친인척 (치매 환자분 제외)에 대해 이야기 해 보겠습니다. 그분과 얼마나 자주 연락을 주고 받으시나요?

0 = 한달에 한번 미만
1 = 한달에 한번
2 = 한달에 여러번
3 = 매주
4 = 일주일에 여러번
5 = 매일

3. 치매환자분을 제외하고 가깝다고 느끼는 친지(형제포함)는 몇명정도 됩니까? 말하자면 귀하께서 편하게 느끼시고 개인적인 일도 이야기 할 수 있으며 도움을 요청할 수 있는 분은 몇명정도 되나요?

0 = 없음
1 = 한명
2 = 두명
3 = 세명~네명
4 = 다섯명~여덟명
5 = 아홉명 이상

4. 가깝다고 느끼는 친구는 몇명정도 됩니까? 말하자면 귀하께서 편하게 느끼시고 개인적인 일도 이야기 할 수 있으며 도움을 요청할 수 있는 친구은 몇명정도 되나요?

0 = 없음
1 = 한명
2 = 두명
3 = 세명~네명
4 = 다섯명~여덟명
5 = 아홉명 이상

5. 지난 한달동안 몇명의 친구를 만나거나 그들로 부터 소식을 들었습니까?

0 = 없음
1 = 한명
2 = 두명
3 = 세명~네명
4 = 다섯명~여덟명
5 = 아홉명 이상

6. 가장 연락을 많이 하는 친구에 대해 이야기 해 보겠습니다. 그분과 얼마나 자주 연락을 주고 받으시나요?

0 = 한달 미만
1 = 한달에 한번
2 = 한달에 여러번
3 = 매주
4 = 일주일에 여러번
5 = 매일

7. 귀하께서 중요한 결정을 해야할 때, 의논 할 있는 누군가가 있습니까?

항상 있음	꽤 자주 있음	자주 있음	가끔 있음	드물게 있음	전혀 없음
5	4	3	2	1	0

8. 귀하께서 아시는 다른 사람이 중요한 결정을 해야할 때, 그들은 귀하께 이야기 하나요?

항상 함	꽤 자주 함	자주 함	가끔 함	드물게 함	전혀 하지 않음
5	4	3	2	1	0

9. 전체적으로 귀하께서는 지난 한달 동안 교통편, 가사 일, 정원일, 쇼핑등으로 받은 도움들에 만족하십니까?

매우 만족	적당히 만족	약간 만족	전혀 만족하지 않음
3	2	1	0

10. 귀하께서는 지난 한달 동안 어려울 때 주위로 부터 받은 도움들, 편한함들, 경청들, 귀하에 대한 관심 등에 만족하십니까?

매우 만족	적당히 만족	약간 만족	전혀 만족하지 않음
3	2	1	0

11. 귀하께서는 지난 한달 동안 비슷한 경험을 하는 사람들로 부터 받은 조언들, 설명, 비슷한 경험을 공유한 것들에 만족하십니까?

매우 만족	적당히 만족	약간 만족	전혀 만족하지 않음
3	2	1	0

*다음은 귀하의 가족주의에 대한 의견 (귀하의 가족만을 이야기하는 것이 아니라 전반적으로 가족에 대한 의견)을 보는 질문들입니다. 다른 분들과 상의하시지 마시고 귀하의 의견을 0~4까지의 척도를 이용해 답해 주십시오.

4= 매우 동의
3= 어느정도 동의
2= 잘 모르겠음
1= 어느정도 반대
0= 매우 반대

1. 삼촌, 이모, 고모들이 도움이 필요할 경우 도와드려야 한다.	4	3	2	1	0
2. 18세 이하의 청소년은 거의 모든 수입을 부모님께 드려야 한다.	4	3	2	1	0

4= 매우 동의
3= 어느정도 동의
2= 잘 모르겠음
1= 어느정도 반대
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3. 가족은 중요한 일이 있을 때 가까운 친척 (삼촌, 고모, 사촌등)과 상의 해야 한다.	4	3	2	1	0
4.18세 이상 자녀는 형제, 자매에게 항상 순종해야 한다.	4	3	2	1	0
5. 가족의 욕구가 개인의 욕구보다 항상 중요하다.	4	3	2	1	0
6. 적어도 결혼한 자녀 중 하나는 부모님과 살아야 한다.	4	3	2	1	0
7. 개인이 희생을 하더라도 항상 가족을 외부로 부터 보호해야한다.	4	3	2	1	0
8. 가족은 가족 구성원의 행동에 관여할 수 있는 권리를 가져야 한다.	4	3	2	1	0
9. 배우자의 부모가 도움이 필요하면 언제라도 도와야 한다.	4	3	2	1	0
10. 가족이 반대하는 일은 무엇이라도 피해야 한다.	4	3	2	1	0
11. 친인척 (삼촌, 고모, 조카등)이 도움이 필요하면 같이 살아야 한다.	4	3	2	1	0
12. 가족에게 충성하고 충실해야 한다.	4	3	2	1	0
13.가족은 같은 정치적, 윤리적, 종교적 생각을 지녀야 한다.	4	3	2	1	0
14. 18세이하 자녀는 부모에게 순종해야 한다.	4	3	2	1	0
15. 필요하면 형제, 자매의 도움을 받아서라도 항상 부모를 부양해야 한다.	4	3	2	1	0
16. 배우자의 부모가 도움이 필요하면 같이 살아야 한다.	4	3	2	1	0

*아래의 마지막 질문들은 귀하의 자신에 대한 느낌, 현재 보살피고 계신 환자분에 대한 느낌, 그리고 간병에 대한 느낌에 관한 것들입니다. 얼마나 동의하시는 혹은 반대 하시는지 답해주십시오.

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1. 나는 내 가족 (환자)과 과거에 나눴던 대화들과 친교들이 그립다.	4	3	2	1	0
2. 나는 내 가족 (환자)이 과거에 나를 사랑해 줄 수 있었던 때가 그립다.	4	3	2	1	0
나 내 가족 (환자)에게 일어나고 있는 정신적, 육체적변화가 슬프다.	4	3	2	1	0
4. 나는 내 가족 (환자)과 과거에 함께 했던 작은 일들이 그립다.	4	3	2	1	0
5. 나는 내가 알고 있던 사람 (환자) 을 잃는 것이 슬프다.	4	3	2	1	0
6. 나는 내 가족을 돌보느라고 자연스러운 생활을 하지 못하는 점이 아쉽다.	4	3	2	1	0
7. 이 상황이 영원할 것 만 같다.	4	3	2	1	0
8. 나는 내 가족 (환자)와 함께하는 것이 즐겁다. 만약 그/그녀가 없었다면 이 시간을 그리워 했을 것이다.	4	3	2	1	0
9. 나는 좋았던 시절을 회상한다.	4	3	2	1	0
10. 내 가족 (환자)를 간병하는 것은 내 인생에 목표와 의미를 준다.	4	3	2	1	0
11. 신은 당신이 대처할 수 있는 만큼의 시련을 준다.	4	3	2	1	0
12.나는 다른 가족및 친구와 시간을 더 보내지 못하는 것이 아쉽다.	4	3	2	1	0
13.나 희망이 없다. 지푸라기를 잡고 있는 심정이다.	4	3	2	1	0

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14. 과거에 내 가족(환자)와 나눴던 추억은 너무 소중하다.	4	3	2	1	0
15. 나는 강한 사람이다.	4	3	2	1	0
16. 간병하는 일은 내가 내 가족을 돕고 있다는 만족감을 준다.	4	3	2	1	0
17. 나는 기도의 힘을 믿는다. 그것 없이는 난 이일을 할 수 없다.	4	3	2	1	0
18. 나는 우리의 과거 사회생활들이 그립다.	4	3	2	1	0
19. 나는 기쁨을 못느낀다.	4	3	2	1	0
20. 내 가족(환자)이 나를 안아 주거나 “사랑해”라고 말할 때, 모든 것이 가치있게 느껴진다.	4	3	2	1	0
21. 나는 투사이다.	4	3	2	1	0
22. 나는 현재 내 가족(환자)를 돌볼 수 있어 기쁘다.	4	3	2	1	0
23. 나는 신께서 모든 것을 해결해 주시리라 믿는다.	4	3	2	1	0
24. 나는 여행 다니지 못하는 것이 안타깝다.	4	3	2	1	0
25. 내가 내 인생을 내 뜻대로 할 수 있게 자유로웠으면 좋겠다.	4	3	2	1	0
26. 가까운 사람과 대화를 나누면 내 능력에 대한 신념이 생긴다.	4	3	2	1	0
27. 비록 내 인생에 어려운 일들이 있지만 내 미래가 기대된다.	4	3	2	1	0
28. 내 가족을 간병하는 일은 새로운 나를 발견하게 해 주었다.	4	3	2	1	0

4= 매우 동의
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29. 나는 신이 이 일을 주신 이유가 있다고 생각한다.	4	3	2	1	0
30. 내 가족 (환자)를 간호하기 위해 포기했던 내 직장과 다른 개인적인 이득들이 아쉽다.	4	3	2	1	0
31. 난 내 가족(환자)의 질병에 갇힌 느낌이 든다.	4	3	2	1	0
32. 삶의 질이 어떠 하더라도 모든 시간이 축복이다.	4	3	2	1	0
33. 현재의 상황을 최선은 아니지만 나는 내 가족 (환자)을 간병하는 것으로 만족을 얻는다.	4	3	2	1	0
34.우리는 미래가 있었지만 내 가족의 치매로 사라져 버렸다.	4	3	2	1	0
35.신은 선하시다.	4	3	2	1	0
36.난 내 가족 (환자)의 유머가 그립다.	4	3	2	1	0
37.난 내가 도망갈 수 있었으면 좋겠다.	4	3	2	1	0
38.일상이 축복이다.	4	3	2	1	0
39.여기가 내가 있어야 할 곳이고 나는 이일에 최선을 다해야 한다.	4	3	2	1	0
40.나는 내가 생각하는 것보다 훨씬 강하다.	4	3	2	1	0
41.내 인생의 질은 떨어지고 있다	4	3	2	1	0
42.난 매일 아침을 오늘도 우리가 함께 할 아름다운 날들이 있음에 기뻐하며 시작한다.	4	3	2	1	0
43. 내 가족을 간병하는 것은 나를 훨씬 강하고 나은 사람으로 만들어 준다.	4	3	2	1	0

***참여해 주셔서 감사합니다. 설문지를 보내드린 봉투에 넣어 가능한 빨리 보내주시면 감사하겠습니다.**

REFERENCES

Acton, J. G., & Kang, J. (2001). Interventions to reduce the burden of caregiving for an dult with dementia: A meta-analysis. *Research in Nursing & Health, 24*, 349-360.

Administration on Aging (AoA). (2004). *A Profile of Older American: 2004.* U. S. Department of Health and Human Service. Washington, D.C.

Adams, B., Aranda, M., Kemp, B., & Takagi, K. (2002). Ethnic and gender differences in distress among Anglo American, African American, Japanese American, and Mexican American spousal caregivers of persons with dementia. *Journal of Clinical Geropsychology, 8*(4), 279-301.

Agronin, M. (2004). Practical guides in psychiatry: Dementia. Philadelphia, PA: ippinncott Williams & Wilkins.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders IV TR.* Washington, DC: American Psychiatric Association.

Allen, R., Kwak, J., Lokken, K., & Haley, W. (2003). End-of-life issues on the context of Alzheimer's disease. *Alzheimer's Care Quarterly, 4*, 312-330.

Aranda, M. (2001). Racial and ethnic factors in dementia care-giving research in the U.S. *Aging and Mental Health, 5*(supplement 1), S116-S123.

Aranda, M., & Knight, B. (1997). The influence of ethnicity and culture on the caregiver stress and coping process: A socio-cultural review and analysis. *The Gerontologist, 37*(3), 342-354

Ashley, N., & Kleinpeter, C. (2002). Gender differences in coping strategies of spousal dementia caregivers. *Journal of Human Behavior in the Social Environment, 6*(2), 31-48.

Bardis, P. (1959a). A comparative study of familism. *Rural Sociology, 24,* 362-371.

Bardis, P. (1959b). A familism scale. *Marriage & Family Living, 21,* 340-341

Beeson, R., Horton-Deutsch, S., & Farran, C. (2000). Loneliness and depression in aregivers of persons with Alzheimer's disease or related disorders. *Issues in ental Health Nursing, 21*(8), 779-806.

Berry, J. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An international review, 46*(1), 5-33.

Boerner, K., Schulz, R., & Horowitz, A. (2004). Positive aspects of caregiving and daptation to bereavement. *Psychology and Aging, 19*(4), 668-675.

Brown, K., & Browne, C. (1998). Perceptions of dementia, caregiving, and help seeking among Asian and Pacific Islander Americans. *Health and Social Work, 23*(4), 262-275.

Bullock, K., Crawford, S., & Tennstedt, S. (2003). Employment and caregiving: xploration of African American caregivers. *Social Work, 48*(2), 150-162.

Cahill, S. (1997). Caring in families: What motivates wives, daughters, and daughters-in-aw to provide dementia care. *Journal of Family Studies, 5*(2), 235-247.

Cartwright, J., Archbold, P., Stewart, B., & Limandri, B., (1994). Enrichment processes in family caregiving to frail elders. *Advanced Nursing Science, 17*(1), 31-43.

Chappell, N., & Reid, R. (2002). Burden and well-being among caregivers: Examining he distinction, *The Gerontologist, 42*(6), 772-780.

Chee, Y., & Levkoff, S. (2001). Culture and dementia: Accounts by family caregivers and health professionals for dementia-affected elders in South Korea. *Journal of Cross-Cultural Gerontology, 16,* 111-125.

Chiu, L., Emblen, J., Hofwegen, L., Sawatzky, R., & Meryerhoff, H. (2004). An integrative review of the concept of spirituality in the health science. *Western journal of nursing research, 26*(4), 405-428.

Chumbler, N., Grimm, J., Cody, M., & Beck, C. (2003). Gender, kinship and caregiver burden: The case of community-dwelling memory impaired seniors. *International Journal of Geriatric Psychiatry, 18*, 722-732.

Clyburn, L., Stones, M., Hadjistavropoulos, & Tuokko, H. (2000). Predicting caregiver burden and depression in Alzheimer's disease. *Journal of Gerontology: Social Sciences, 55B*(1), S2-S13.

Coen, R., Swanwick, G., O'boyle, C., & Coakley, D. (1996). Behavior disturbance and other predictors of care burden in Alzheimer's disease. *International Journal of Geriatric Psychiatry, 12,* 331-336.

Cohen, C., Colantonio, A., & Vernich, L. (2002). Positive aspects of caregiving: Rounding out the caregiver experience. *International Journal of Geriatric Psychiatry, 17*(2), 184-188.

Connell, C., Janevic, M., & Gallant, M. (2001).The costs of caring: Impact of dementia on family caregivers. *Journal of Geriatric Psychiatry & Neurology, 14*(4), 179-187.

Covinsky, K., Newcomer, R., Fox, P., Wood, J., Sands, L., Dane, K., & Yaff, K. (2003). Patient and caregiver characteristics associated with depression in caregivers of patients with dementia, *Journal of General Internal Medicine, 18*, 1006-1014.

Crowther, M., Parker, M., Achenbaum, W., Larimore, W., & Koenig, H. (2002).

Rowe and Kahn's model of successful aging revisited: Positive spirituality—The forgotten factor. *The Gerontologist, 42*(5), 613-620.

Delongis, A., Coyne, C., Dakof, G., Folkman, S., & Lazarus, R. (1982). Relationship of daily hassles, uplifts, and major life events to health status. *Health Psychology, 1.* 119-136.

Doka, K, & Carter, R. (2001). Caregiving and loss. Washington; Hospice foundation of America.

Doka, K. & Davison, J. (1998). *Living with grief: Who we are, how we grieve.* Washington, DC: Hospice Foundation of America.

Dilworth-Anderson, P. Goodwin, P., & Williams, S. (2004). Can culture help explain the physical health effects of caregiving over time among African American caregivers? *Journals of Gerontology: Series B: Psychological Sciences and Social Sciences, 59B*(3), 138-S145.

Dilworth-Anderson, P., Williams, I., & Gibson, B. (2002). Issues of race, ethnicity, and culture in caregiving research: A 20-year review (1980-2000). *The Gerontologist, 42*(2), 237-272.

Dressler, W. Balieiro, M., & Santos, J. (1997). The Cultural Construction of social support in Brazil: Associations with health outcomes. *Culture, Medicine, and Psychiatry, 21*(3), 303-335.

Dura, J., Stukenberg, K., & Kiecolt-Glaser, J. (1991). Anxiety and depressive disorders in adult children caring for demented parents. *Psychology and aging, 6,* 467-473.

Farren, C. (1997). Theoretical perspectives concerning positive aspects of caring for elderly persons with dementia: Stress/adaptation and existentialism. *The*

Gerontologist, 37(2), 250-256.

Farran, C., Keane-Hegerty, E., Salloway, S., Kupferer, S., & Wilken, C. (1991). Finding meaning: An alternative paradigm for Alzheimer's disease family caregivers, *The Gerontologist, 31*(4), 483-489.

Farren, C., Miller, B., Kaufman, J., Donner, E., & Fogg, L. (1999). Finding meaning through caregiving: Development of an instrument for family caregivers of persons with Alzheimer's disease. *Journal of clinical psychology, 55*(9), 1107-1125.

Farren, C., Paun, O., & Elliott, M. (2003). Spirituality in multicultural caregivers of persons with dementia. *Dementia, 2(*3), 353-377.

Garity, J. (1997). Stress, learning style, resilience factors, and ways of coping in Alzheimer family caregivers, *American Journal of Alzheimer's Disease, July/August,* 171-178.

Gaugler, J., Kane, R., Kane, R., & Newcomer, R. (2005). The longitudinal effects of early behavior problem in the dementia caregiving care, *Psychology and Aging, 20*(1), 100-116.

Golden, M. (1964). *Assimilation in American life.* New York: Oxford University Press.

Golden, M. (1978). *Human nature, Class, and Ethnicity.* New York: Oxford University Press.

Greene, R. R. ([1986] 2000). *Social work with the aged and their families*. Hawthorne, NY: Aldine de Gruyter.

Greene, R. R. & Livingston, N. (2002). A social construct. In R. R. Greene (Eds.). *Resiliency Theory: An Integrated Framework for Practice, Research, and Policy* (pp.63-94).

Washington, DC: NASW Press.

Greene, R. R. & Conrad, A. (2002). Basic assumptions and terms. In R. R. Greene (Eds.). *Resiliency Theory: An Integrated Framework for Practice, Research, and Policy* (pp.29-62). Washington, DC: NASW Press.

Hair, J., Anderson, R. E., Tatham, R. L., & Black, W. C. (1998). *Multivariate data analysis* (5th ed.). Upper Saddle River, NJ: Prentice Hall.

Haley, W., Gitlin, L., Wisniewski, S., Mahoney, F., Coon, D., Winter, L., Corcoran, M., Schinfeld, S., & Ory, M. (2004). Well-being, appraisal, and coping in African-American and Caucasian dementia caregivers: findings from the REACH study. *Aging and Mental Health, 8*(4), 316-329.

Harwood, D., Ownby, R., Burnett, K., Barker, W., & Duara, R. (2000). Predictors of appraisal and psychological well-being in Alzheimer's disease family caregiver, *Journal of Clinical Geropsychology, 6*(4), 279-297.

Hebert, L.E., Beckett, L.A., Scher, P.A., Evans, D.A. (2001). Annual incidence of Alzheimer disease in the United States projected to the years 2000 through 2050. Alzheimer Disease and Associated Disorders, 15(4), 169-173.

Hebert, L., Scherr, P., Beckett, L., Albert, M., & Pilgrim, D. (1995). Age-specific incidence of Alzheimer's disease in a community population. *Journal of the American Medical Association, 273,* 1354-1359.

Hepburn, K., Lewis, M., Narayan, S., Tornatore, J., Bremer, K., & Sherman, C. (2002). Discourse-derived perspective: Differentiating among spouses' experience of caregiving. *American Journal of Alzheimer's Disease and Other Dementias, 17*(4), 213-226.

Heru, A., Ryan, C., & Iqbal, A. (2004). Family functioning in the caregivers of patients with dementia. *International Journal of Geriatric Psychiatry, 19*, 533-537.

Hicks, M., & Lam, M. (1999). Decision-making within the social course of dementia: Accounts by Chinese-American caregivers. *Culture, Medicine & Psychiatry, 23*(4), 415-452.

Hinton, L., Guo, Z., & Hillygus, J. (2000). Working with culture: A qualitative analysis of barriers to the recruitment of Chinese-American family caregivers for dementia research. *Journal of Cross-Cultural Gerontology, 15*(2), 119-137.

Hooker, K., S. R. Bowman, Coehlo, D., Lim, S., Kaye, J., Guariglia, R., & Li, F. (2002). Behavioral change in persons with dementia: Relationships with mental and physical health of caregivers. *Journal of Gerontology: Journal of Gerontology: Psychological Science 57*(5), 453-460.

Hunt, L. Schneider, S., Comer, B. (2004). Should 'acculturation' be a variable in health research? A critical review of research on US Hispanics. *Social Science & Medicine, 59*(5), 973-986.

Hurh, W. (1998). *The Korean Americans.* Westport, CN: Greenwood Press

Hwang, K. (1999). Filial piety and loyalty: Two types of social identification in Confucianism. *Asian Journal of Social Psychology, 2*, 163-183.

Ihara, C. (2004), Are individual rights necessary? A Confucian perspective. In K. Shun, & D. B. Wong (Eds.). *Confucian ethics: A comparative study of self, autonomy, and community* (pp.11-30) . New York: Cambridge University Press.

Janevic, M.,& Conell, C. (2001). Racial, ethnic, and culture differences in the dementia caregiving experience: Recent findings. *The Gerontologist, 41*(3), 334-347.

Jones, P., Zhang, X., Jaceldo-Siegl, K. (2002). Caregiving between two cultures: An integrative experience. *Journal of Transcultural Nursing, 13*(3), 202-209.

Jolicoeur, P., & Madden, T. (2002). The good daughters: Acculturation and caregiving among Mexican-American women, *Journal of Aging Studies, 16*, 107-120.

Kang, S. (2002). *Unveiling the socioculturally constructed multivoiced self.* Lanham, Maryland: University Press of America.

Kao, H., Hsu, M., Clark, L., (2004). Conceptualizing and critiquing culture in health research. *Journal of Transcultural Nursing, 15*(4), 267-277.

Keefe, S., & Padilla, A. M. (1987). Chicano ethnicity. Albuquerque: University of New Mexico Press.

Knight, B., Robinson, G., Longmire, C., Chun, M., Nakao, K., & Kim, J. (2002). Cross cultural issues in caregiving for persons with dementia: Do familism values reduce burden and distress*? Ageing International, 27*(3), 70-94.

Knight, B., Silverstein, M., McCallum, T., & Fox, L. (2000). A sociocultural stress and coping model for mental health outcomes among African American caregivers in southern California. *Journal of Gerontology: Psychological Sciences, 55B*(3), P142-P150.

Kim, I. (2004). A century of Korean immigration to the United States: 1903-2003. In I. J. Kim (Eds.). *Korean-American: Past, present, and future* (pp.13-37). Elizabeth, NJ: Hollym.

Kim, B. (1996). Korean families. In M. McGoldrick et al. (Eds.). *Ethnicity and family therapy.* (pp.280-294). New York: Guilford.

Kim, M., Han, H., Shin, H., Kim, K., & Lee, H. (2005). Factors associated with

depression experience of immigrant populations: A study of Korean immigrants. *Archives of Psychiatric Nursing, 19*(5), 217-225.

Kim, S., & Kim, K. (2001). Intimacy at a distance, Korean American style: Invited Korean elderly and their married children. In L. K. Olson (Eds.). *Age through ethnic lenses: Caring for the elderly in a multicultural society* (pp.45-58). New York: Rowman & Littlefield.

Kim, S., & Lew, L. (1994). Ethnic identity, role integration, quality of life and depression in Korean-American women, *Archives of psychiatric nursing, 8*(6), 348-356.

Kim, J. H. & Theis, S. L. (2000). Korean American caregivers: Who are they? *Journal of Transcultural nursing, 11*(4), 264-273

Koening, T. (2005). Caregivers' use of spirituality in ethical decision-making. *Journal of gerontological social work, 45*(1/2), 157-174.

Koh, J., & Bell, W. (1987). Korean elders in the United States: Intergenerational relations and living arrangement. *The Gerontologist, 27*(1), 66-71.

Kolanowski, A.,Fick, D., Waller, J., & Shea, D. (2004). Spouse of persons with dementia: Their healthcare problems, utilization, and cost. *Research in Nursing and Health, 27,* 296-306.

Korean American Coalition-Census Information Center, & Center for Korean American and Korean Studies. (2003). *100 years of American history: The Korean American population*. Retreived October 10, 2005, from http://www.calstatela.edu/centers/ckaks/census_tables.html.

Korean Ministry of Health and Welfare (n.d.) Information on Korean elders. Retrieved November 26, 2005, from

http://www.hp.go.kr/html/healthLife/contents.html?code=948

Kramer, B. (1997). Gain in the caregiving experience: Where are we? What next? *The Gerontologist, 37*(2), 218-232.

Krause, N., & Markides, K. (1990). Measuring social support among older adults. International Journal of Aging and Human Development, 30(1), 37-53.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Lawton, M. Moss, M. Kleban, M. (1991). A two-factor model of caregiving appraisal and psychological well-being. *Journals of Gerontology, 46*(4), 181-P189.

Lee, H., Brennan, P., & Daly, B. (2001). Relationship of empathy to appraisal, depression, life satisfaction, and physical health in informal caregivers of older adults. *Research in nursing & health, 24*, 44-56.

Lee, M., Crittenden, K., & Yu, E. (1996). Social support and depression among elderly Korean immigrants in the United States. *International Journal of Aging and Human Development, 42*(4), 313-326.

Lee, E., Farren, C., Tripp-Reimer, T., & Sadler, G. (2003). Assessing the cultural appropriateness of the finding meaning through caregiving scale for Korean caregivers. (2003). *Journal of Nursing Measurement, 11*(1), 19-28.

Lee, J-S., Koeske, G., & Sale, E. (2004). Social support buffering of acculturative stress: a study of mental health symptoms among Korean international student. *International Journal of Intercultural Relations, 28,* 399-414.

Lee, E., & Farran, C. (2004). Depression among Korean, Korean American, and Caucasian American family caregivers. *Journal of Transcultural Nursing, 15*(1),

18-25.

Lee, S. Sobal, J., & Frongillo, E. (2003). Comparison of models of acculturation: The case of Korean Americans. *Journal of Cross-Cultural Psychology, 34*(3), 282-296.

Lee, Y., & Sung, K. (1998). Cultural influences on caregiving burden: Cases of Koreans and Americans. *International Journal of Aging & Human Development, 46*(2), 125-141

Lubben, J. (1988). Assessing social networks among elderly populations. *Family & Community Health, 11*(3), 42-52.

Luna, I., Ardon, E., Lim, Y., Cromwell, S., Phillips, L., & Russell, C. (1997). The relevance of familism in cross-cultural studies of family caregiving. *Western Journal of Nursing Research, 18*(3), 267-274.

Lynn, L., Kang, K., & Ludman, E. (1999). Korean elderly: Diet, food beliefs, and acculturation. *Journal of Nutrition for the Elderly, 19*(2), 1-15.

Marin, G., Sabogal, F., Marin, B. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9*(2), 183-205.

Martire, L., Stephens, M., Atienza, A. (1997). The interplay of work and caregiving: Relationships between role satisfaction, role involvement, and caregivers' well-being. *Journals of Gerontology: Series B: Psychological Sciences & Social Sciences, 52B*(5), 279-289.

McKibbin, C.L., Walsh, W., Rinki, M., Koin, D., & Gallagher-Thomson, D. (1999). Lifestyle and health behavior among female family dementia caregivers: a comparison of wives and daughters. *Aging & Mental Health, 3*(2), 165-172.

McMillen, J. (1999). Better for it: How people benefit from adversity. *Social Work, 44*(5),

455-468.

MetLife Mature Market Institute, (November, 1999). *The MetLife juggling Act study: Balancing caregiving with work and the costs involved*. New York: Metropolitan Life Insurance Company.

Miller, A., & Chandler, P. (2002). Acculturation, resilience, and depression in midlife women from the former Soviet Union. *Nursing Research, 51*(1) 26-32.

Miller, B., & Cafasso, L. (1992). Gender differences in caregiving: Fact or artifact. *The Gerontologist, 32*(4), 498-507.

Moon, A. (1996). Predictors of morale among Korean immigrant elderly in the USA. *Journal of Cross-Cultural Gerontology, 11*(4),351-367.

Moon, A., Lubben, J., & Villa, V. (1998). Awareness and utilization of community long-term care services by elderly Korean and non-Hispanic White Americans. *The Gerontologist, 38*(3), 309-316.

Moore, M. J., Zhu, C. W., & Clipp, E, C.. (2001). Informal costs of dementia care: Estimates from the national longitudinal caregiver study. Journal of Gerontology: Social Science, 56B (4), S219-S228.

Narayan, S., Lewis, M., Tornatore, J., Hepburn, K., & Cocoran-Perry, S. (2001). Subjective responses to caregiving for a spouse with dementia. *Journal of Gerontological Nursing, 27*(2), 19-28.

National Institute of Aging (2003). 2001-2002 Alzheimer's Disease Progress Report (NIH Publication No. 03-5333). Washington, DC: U.S. Department of Health and Human Services.

National Alliance for Caregiving & AARP. (2004). Caregiving in the U.S. Washington,

DC: AARP.

Navaie-Waliser, M., Feldman, P., Gould, D., Levine, C., Kuerbis, A., & Donelan, K. (2001). The experiences and challenges of informal caregivers: Common themes and differences among Whites, Blacks, and Hispanic, *The Gerontologist, 41*(6), 733-741.

Noonan, A. E. and S. L. Tennstedt (1997). Meaning in caregiving and its contribution to caregiver well-being. *Gerontologist 37*(6), 785-794.

Nolan, M., Grant, G., & Keady, J. (1996). *Understanding family care: A multidimensional model of caring and coping.* Bristol, PA: Open University Press.

Ory, M., Hoffman, R., Yee, J., Tennstedt, S., Schulz, R. (1999). Prevalence and impact of caregiving: A detailed comparison between dementia and nondementia caregiver, *The Gerontologist, 39*(2), 177-185.

Ory, M.G., Yee, J.L. Tennstedt, S.L., & Schulz, R. (2000). The extent and impact of dementia care: Unique challenges experienced by family caregivers. In R. Schulz (Eds.), *Handbook on Dementia Caregiving: evidence-based interventions in family caregiving.* New York; Springer Publishing Company.

Padilla, A., & Perez, W. (2003). Acculturation, social identity, and social cognition: A new perspective. *Hispanic Journal of Behavioral Science, 25*(1), 35-55.

Padilla, Y. C., & Villalobos, G. (2007). Cultural responses to health among Mexican American women and their families. *Family and Community Health, 30*(1S), S24-S33.

Paun, O. (2003). Older women caring for spouses with Alzheimer's disease at home: Making sense of the situation. *Health Care for Women International 24*, 292-312.

Pot, A., Deeg, D., van Dyck, R., & Jonker, C. (1998). Psychological distress of caregivers: The mediator effect of caregiving appraisal. *Patient Education and Counseling, 34*(1), 43- 51.

Picot, S., Debanne, S., Namazi, K., & Wykle, M. (1997). Religiosity and perceived rewards of black and white caregivers. *The Gerontologist, 37*(1), 89-101.

Pierce, T., Lydon, J., & Yang, S. (2001). Enthusiasm and moral commitment: What sustains family caregivers of those with dementia. Basic & Applied Social Psychology, 23(1), 29-41.

Pinquart, M., & Sorensen, S. (2003). Associations of stressor and uplifts of caregiving with caregiver burden and depressive mood: A meta-analysis. *Journal of Gerontology: Psychological Science, 58B*(2), 112-128.

Pyke, K. (2000). 'The normal American family' as an interpretive structure of family life among grown children of Korean and Vietnamese immigrants. *Journal of Marriage & the Family, 62*(1), 240-255.

Rapp, S., & Chao, D. (2000). Appraisals of strain and gain: Effects on psychological wellbeing of caregivers of dementia patients. *Aging and Mental Health, 4*(2), 142-147.

Rapp, S., Shumaker, S., Schmidt, S., Naughton, M., & Anderson, R. (1998). Social resourcefulness: its relationship to social support and wellbeing among caregivers of dementia victims. *Aging and Mental Health, 2*(1), 40-48.

Redfield, R., Linton, R., & Herskovits, M. (1936). Memorandum on the study of acculturation. *American Anthropologist, 38,* 149-152.

Roff, L., Burgio, L., Gitlin, L., Nichols, L, Chaplin, W., & Hardin, M. (2004). Positive

aspects of Alzheimer's caregiving: The role of race. *Journal of Gerontology: Psychological sciences, 59B(*4), 185-190.

Rose-Rego, S.K., Strauss, M.E., & Smyth, K.A. (1998). Differences in the perceived well-being of wives and husbands caring for persons with Alzheimer's disease. *The Gerontologist, 38,* 224-230.

Roth, D.L., Haley, W.E., Owen, J.E., Clay, O.J.,& Goode, K. (2001). Latent growth model of the longitudinal effects of dementia caregiving: A comparison of African American and White family caregiver. *Psychology & Aging, 16*(3), 427-436.

Rubin, A., & Babbie, E. (2001). *Research methods for social work (4th ed.).* Belmont, CA: Brooks/Cole.

Rutter, M. (1987). Psychological resilience and protective mechanisms. American Journal of Orthopsychiatry, 57, 316-331.

Russo, J., Vitaliano, P., Brewer, D., Katon, W., & Becker, J. (1995). Psychiatric disorders in spouse caregivers of care-recipients with Alzheimer's disease and matched controls: A diathesis-stress model of psychopathology. *Journal of Abnormal Psychology, 104*,197-204.

Saleebey, D. (2002). Introduction: Power in the People. In D. Saleebey (Eds.), *The strengths perspective in social work practice(3rd ed.)*(pp.176-194). Boston, MA; Allyn and Bacon.

Schulz, R. (2000). *Handbook on dementia caregiving: Evidence-based interventions for family caregivers.* New York, NY, US: Springer Publishing

Schulz, R., & Beach, S. (1999). Caregiving as a risk factor for mortality: The caregiver health effects study. *Journal of American Medical Association, 282* (23), 2215-

2219.

Schulz, R., O'Brien, A., Bookwala, J. & Fleissnger, K. (1995). Psychiatric and physical morbidity effects of dementia care-giving: Prevalence, correlaters, and causes. *The Gerontologist, 35,* 771-791.

Schwab, J. C. (2007). Data analysis and computers I & II: School of Social Work, Fall 2006 and Spring 2007, Unpublished course materials, University Texas at Austin.

Sherrell, K., Buckwalter, K., & Morhardt, D. (2001). Negotiating family relationships: Dementia care as a midlife developmental task. *Families in Society: The Journal of Contemporary Human Services, 82(*4), 383-392.

Skinner, J. (2002). Acculturation: Measures of ethnic accomodation to the dominant American culture. In J. H. Skinner, H. John, J. A. Teresi, D. Holmes, S. M. Stahl, & A. L. Stewart. *Multicultural measurement in older populations* (pp. 37-51). New York, NY: Springer Publishing Co.

Social Science Research Council (1953). Acculturation: An exploratory formulation. *American Anthropologist, 56,* 973-1002.

Song, L., Biegel, D., & Milligan, S. (1997). Predictors of depressive symptomatology among lower social class caregivers of persons with chronic mental illness. *Community Mental Health Journal, 33,* 269-286.

Soper, D.S. (2007). *Post-hoc statistical power calculator.* Retrieved May 29, 2007, from http://www.danielsoper.com/statcalc/calc09.aspx

Strawbridge, W., Wallhagen, M., Shema, S., & Kaplan, G. (1997). New burden or more of the same? Comparing grandparent, spouse, and adult-child caregivers. *The Gerontologist, 37*(4), 505-510.

Stuckey, J., & Smyth, K. (1997). The impact of social resources on the Alzheimer's disease caregiving experience. *Research on Aging, 19*(4), 423-441.

Suinn, R., Richard-Figueroa, K., Lew, S., & Vigil, P. (1987). The Suinn-Lew Asian Self-Identity Acculturation Scale: An initial report. *Educational and Psychological Measurement, 47*(2), 401-407.

Sung, K. (1995). Measures and dimensions of filial piety in Korea. *The Gerontologist, 35*(2), 240-247.

Sung, K. (1997). Filial piety in modern times: Timely adaptation and practice patterns. *Australasian Journal on Ageing, 17*(1, Supplement), 88-92.

Sung, K. (2001). Elder respect: Exploration of ideals and forms in East Asia. *Journal of Aging Studies, 15*(1), 13-26.

Tarlow, B., Wisniewski, S., & Belle, S. (2004). Positive Aspects of Caregiving: Contributions of the REACH project to the development of new measures for Alzheimer's caregiving. *Research on Aging, 26*(4), 429-453.

Tebb, S., & Jivanjee, P. (2000). Caregiver isolation: An ecological model. *Journal of Gerontological social work, 34*(2), 51-72.

Tebes, J., & Irish, J. (2000). Promoting resilience among children of sandwiched generation caregiving women through caregiver mutual help. *Journal of Prevention & Intervention in the Community, 20*(1/2), 139-158.

Teri, L., Traux, P., Logsdon, R., Uomoto, J., Zarit, S., & Vitaliano, P. (1992). Assessment of behavioral problems in dementia: The revised memory checklist. *Psychology and aging, 7*(4), 622-631.

The Canadian Study of Health and Aging Working Group. (2002).Patterns and health

effects of caring for people with dementia: The impact of changing cognitive and residential status, *The Gerontologist, 42*(5), 643-652.

Thoits, P. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior, 36*(Suppl.), 53-79.

The National Women's Health Information Center. (2002). *What is caregiving?* Retrieved January 25, 2005, from http://www.4woman.gov/faq/caregiver.pdf

Tornatore, J., & Grant, L. (2002). Burden among family caregivers of persons with Alzheimer's disease in nursing homes. *The Gerontologist, 42*(4), 497-506.

Turner, R. S. (2003). Neurologic aspects of Alzheimer's disease. In P. A. Lichetnburg, D. L. Murman, & A. M. Mellow (Eds.). *Handbook of dementia: Psychological, neurological, and psychiatric perspective* (pp.1-24). Hobkken, New Jersey: John Wiley & Sons, Inc.

U.S. Bureau of Census. (2002). *The Asian Population: 2000.* U.S. Department of Commerce.

United States Department of Health and Human Services Office of Minority Health (2000). *Assuring cultural competence in health care: Recommendations for national standards and outcomes-focused research agenda*. Washington, DC: U. S. Government Printing Office.

Valle, R. (1997). *Caregiving across cultures: Working with dementing illness and ethnicity diverse population.* Washington, D.C.: Taylor & Francis.

Vrabec, N. (1997). Literature review of social support and caregiver burden, 1980 to 1995. *Image: Journal of Nursing Scholarship, 29*(4), 383-388

Walker, R., & Pomeroy, E. (1996). Depression or grief? The experience of caregivers of

people with dementia. *Health & Social Work, 21*(4), 247-254.

Watari, K., & Gatz, M. (2004). Pathways to care for Alzheimer's disease among Korean Americans. *Cultural Diversity and Ethnic Minority Psychology, 10*(1), 23-38.

Women's Institute for Secure Retirement (2002). *Instead of golden years, America's inority women face bleak retirement in poverty*. Retrived October 10, 2005, from http://www.wiser.heinz.org/prminorityretirement.html

Yao, X. (2000). *An Introduction to Confucianism.* Cambridge, UK: Cambridge University Press

Yates, M. Tennstedt, S., & Chang, B. (1999). Contributors to and mediators of sychological well-being for informal caregivers. *Journals of Gerontology: Series : Psychological Sciences and Social Sciences, 54B*(1), P12-P22.

Yalom, I. (1995). The theory and practice of group psychotherapy (4th ed.). New York, NY: Basic Books, Inc.

Yee, J., & Schulz, R. (2000). Gender differences in psychiatric morbidity among family caregivers: A review and analysis. *The Gerontologist, 40*(2), 147-164.

Yeh, K., & Bedford, O. (2003). A test of the dual filial piety model. *Asian Journal of ocial Psychology, 6,* 215-228.

Yong, F., & McCallion, P. (2003). Hwabyung as caregiving stress among Korean-merican caregivers of a relative with dementia. *Journal of Gerontological Social ork, 42(*2), 3-19.

Youn, G., Knight, B., Jeong, H., & Benton, D. (1999). Differences in familism values and caregiving outcomes among Korean, Korean American, and White American dementia caregivers. *Psychology & Aging, 14*(3), 355-364.

Zanetti, O., Frisoni, G., Bianchetti, A., Tamanza, G., Cigoli, V., & Traubucchi, M. (1997). Depressive symptoms of Alzheimer caregivers are mainly due to personal rather han patient factors. International Journal of Geriatric Psychiatry, 13, 358-367.

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